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Family Estrangement and Hospital Readmission Rates Among Severely Mentally Ill Adults

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Family Estrangement and Hospital Readmission Rates

Among Severely Mentally Ill Adults

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By

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ABSTRACT

Most crisis stabilization, and mental health treatment in general, is delivered solely to the individual in crisis, by professionals who are careful to protect the individual's right to privacy. An unintended consequence of this objective, unfortunately, can be the undermining of the potentially significant role played by family members in the treatment, maintenance, and stabilization of individuals with mental illness. Without family involvement, some individuals burdened by mental illness slowly and steadily decline. This study investigates how familial relationships impact mental health problems, specifically psychiatric hospital readmissions. The goal of this study is to determine whether being estranged from one's family increased the number of times an individual was readmitted to an inpatient psychiatric hospital. This study makes use of de-identified, archival data from Ventura County Behavioral Health (California), to examine the association between family support and inpatient hospital readmission rates. This data set provides information regarding clients' previous hospitalizations, if any, Crisis Team contacts, number of years of outpatient mental health treatment, and documented family support. Furthermore, this study aims to identify possible recommendations for improving family involvement in an individual's care in an attempt to reduce the number of inpatient psychiatric hospital readmissions. These treatment recommendations will seek to improve the quality of life for the individual suffering from mental illness, as well as their family; as well as strive to save scarce resources (personal and societal). In summary, this study aims to shine light on a bleak and controversial issue that is impacting millions of Americans. Better research may lead to earlier diagnosis and better treatment of mental illness, leading to longer, happier lives for individuals who are touched by mental illness. The consequences of inadequate treatment for the mentally ill population are too devastating to ignore. May they no longer have to bear the burden

of incarceration, potentially avoidable hospital readmissions, homelessness and the stigma that follows them wherever they go. This dissertation is available in open access at AURA: Antioch University Repository and Archive, http://aura.antioch.edu and OhioLink ETD Center, http://www.ohiolink.edu/etd

Table of Contents

Chapter I Introduction

According to the National Institute of Mental Health (2015), 1 in 5 American adults has a mental health disorder- a total of close to 43 million people. Some of these adults will experience symptoms acute enough to require inpatient psychiatric hospitalization. According to data gathered from the 2004 Substance Abuse and Mental Health Services Administration biennial Survey of Mental Health Organizations, inpatient psychiatric hospital admissions among adults rose to 910 per 100,000 civilians, a significant increase given that between 1990 and 2000 admissions had dropped from 833 to 714 per 100,000 (J. Blader, 2011). Most of these admissions occurred in facilities that offer acute, short-term care, such as private psychiatric hospitals and general hospital psychiatric services. Also taken into account when analyzing admission trends are long-term inpatient services such as county and state-run psychiatric hospitals (J. Blader, 2011).

Many individuals diagnosed with a mental illness are generally able to manage their symptoms with medication and outpatient treatment, despite regular fluctuations in their level of functioning; such is the nature of most psychiatric disorders. Blader (2011) sheds light on this concept noting that once symptoms become unmanageable for the individual, they often require admission to an inpatient psychiatric hospital. Most often such admissions are to short-term care settings within a general or psychiatric hospital. With that being said, it is assumed that mental health professionals across the board agree that best practice for client care is to provide the most effective treatment in the least restrictive setting. Essentially, inpatient psychiatric hospitalization is viewed as a last resort treatment when all other resources have been exhausted.

Feifel (2008) shared a similar philosophy about psychiatric hospitalization, stating that for most psychologists and psychiatrists, to initiate such hospitalization would be a declaration that the client in question has become so impaired that they are not likely to be able to manage their illness in an outpatient setting without imminent risk of harm to self or others. It is Feifel's view (2008) that most professionals prefer to utilize psychiatric hospitals as a last resort only when extreme safety risks can no longer be ignored. After the decision has been made to psychiatrically hospitalize an individual in need, the main focus becomes rapid stabilization (Feifel, 2008).

First and foremost, the goal within an inpatient psychiatric hospital is crisis stabilization, achieved through intense biopsychosocial intervention, such as medication and group and individual therapy. The reality of treatment protocols offered in psychiatric hospitals today is that they do not differ tremendously from what individuals might receive on an outpatient basis, with the exception that these treatment are delivered in a locked setting, allowing staff to safely monitor patients around the clock. The criteria for admission and authorization for continued inpatient psychiatric care is becoming increasingly more stringent (J. Blader, 2011). These factors, combined with lower rates of reimbursement from insurance providers, limit the ability of inpatient hospitals to provide aggressive, specialized care, involving highly trained staff-therapeutic interventions beyond what is typically seen in general outpatient maintenance. Without the availability of tailored, intensive, multi-modal treatment in these settings, and given poor compliance with outpatient treatment, many individuals get caught in a revolving door of multiple admissions to psychiatric hospitals.

Research produced by Hillman (2001) and Segal and Burgess (2006) suggests that anywhere between 37% and 53% of psychiatrically hospitalized patients are readmitted within

12 months of being discharged. This rate is extremely high, and alarming, not only to service providers in the field, but to loved ones and community members alike. High inpatient readmission rates are often interpreted as a failure of the patient's previous discharge planning, with the blame often falling on mental health professionals. For example, one might assume that the client was discharged prematurely before their symptoms were stabilized, that they were not given adequate outpatient resources to follow up with, or that their medication was never obtained due to a lack of transportation to the pharmacy. While any of these scenarios may be true in some cases, a lack of current research in the area impairs behavioral health professionals' ability to effectively identify core issues that might be ameliorated by substantive changes in policy or reimbursement. Hence, society in general and the mental health community specifically share a keen interest in understanding why patients are coming back to the inpatient hospital settings so quickly.

There are many factors that contribute to the high number of psychiatric inpatient hospital readmissions among chronically mentally ill adults. This study aims to specifically investigate the correlation between patient-identified family estrangement and, hospital readmission rates among this population. In conducting this research, it is expected that other factors contributing to such readmissions will be uncovered. A better understanding of factors influencing psychiatric hospitalization readmission may aid in early intervention programs aiming to support individuals on their journey through mental illness, perhaps not only keeping them connected with their support system, but also with community resources, thus reducing the readmission rate to psychiatric inpatient settings.

Not only does hospital readmission have a negative impact on the individual receiving the services, it is also costly for hospitals and consumers, as well as being a drain on professional

resources. A better understanding of the factors contributing to inpatient psychiatric hospital readmissions may also impact the fiscal resources of hospitals and consumers.

The sad reality, and one that occurs far too often, is that once individuals are stabilized at an inpatient psychiatric hospital, assuming they stay long enough for treatment to have an impact, they are released to an outside world posing profound challenges. Without the support of family and friends upon discharge, they will, more often than not, return to their previous level of illness severity. Brief, crisis-based hospitalizations are unlikely to have addressed poor coping skills and bad decision making that may have contributed to hospitalization in the first place. According to research conducted by Robert P. Stewart, for the National Association of Social Workers, Inc. (1984), it would be beneficial to both the patient and their family to create a positive union between the family entity and hospital once the patient has been admitted. There is often a disconnect from the family once their loved one is admitted; this phenomenon was referred to by Biddle (1978) as "family withdrawal".

According to Biddle's findings (1978), family members have often been through profound experiences with the individual at this point and are physically and emotionally exhausted. They therefore tend to release responsibility to the hospital and expect that the facility will provide solutions for their loved ones' problems; solutions that they recognize they were not able to provide themselves. The need for a respite, combined with these high expectations, may lead to their not so subtle discontinuation of involvement. Relying on the facility to "fix" their loved one, Biddle found that the family will step back to allow the treatment team to do whatever it is that they need to do. What the family may not consider at this point is the negative impact that this has on their loved one and their ongoing care. For example, their loved one may feel abandoned.

Stewart (1984) also explored the strenuous process that families go through once a loved one is admitted to a psychiatric hospital. Along with Biddle, he too noted a period of time in which a family disengages with their loved one once the crisis period is over and their relative is safely contained in a hospital setting. Stewart referred to this period of time as stage 2 (of 4), 'Separation.' Steward (1984) recognized that the day after a hospital admission, families tend to experience one of two extreme reactions. In the first, family members experience a sense of relief and withdraw from the situation in an attempt to restabilize themselves. Conversely, a family may experience a sense of increased anxiety due to the separation from their loved one and the possible pending rejection.

Much like Stewart highlighted, Biddle (1987) reported that once a loved one is admitted to a hospital, a family often experiences relief and a diminishment of anxiety. However, this can in turn cause the individual receiving treatment in the hospital to feel further disconnected from their family. In addition, it was noted that family members ultimately began to feel "helpless, guilty, and removed from the helping process (Biddle, 1987)." One can imagine that if this process happens over and over again, the gap between a family and their loved one continues to grow until it dissipates completely. Once the relationship ceases to exist, the mentally ill individual often feels like they have no place to go and begins the cycle of poor coping skill utilization.

Chronically mentally ill patients have high rates of drug use and homelessness. According to the results from data gathered for the report, Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health (2015), among the 20.2 million adults who were considered to have a substance use disorder in the last year, 7.9 million (39.1%) had "Any Mental Illness" in the past year. The results from this survey also

suggest that 3.3 percent of all adults in 2014 suffered from both a mental illness as well as a substance use disorder. More specifically, 1 percent of these individuals suffered from a substance use disorder in addition to a serious mental illness. Data from the National Institute on Drug Abuse (NIDA, 2010) show that individuals with certain mental health disorders, for example mood and anxiety disorders, are twice as likely to suffer from a substance use disorder as well.

No one chooses to become an addict. Science has begun to unravel the complicated associations between substance experimentation to dependency and abuse; clearly, that risk is enhanced when substances are used as a maladaptive coping skill. The reality is that substance use disorders are mental health disorders too. Substance use disorders and a wide array of mental health disorders are caused by the same overlapping variables. These variables are things such as a genetic predisposition to the illness, underlying deficits within the brain, exposure to stress or trauma early in life (even while the fetus is developing) and more (NIDA, 2010).

The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), which is one of the field's primary tools for diagnosing mental disorders, includes criteria for substance use disorders. Providers have struggled to treat patients with dual diagnoses effectively, mainly because their symptoms have a much different presentation- for example, they are more persistent, severe, and generally resistant to treatment. However, in the last decade or so, things are taking a turn for better. New treatment approaches are emerging, and proving effective, that suggest co-occurring disorders need to be treated simultaneously and aggressively (NIDA, 2010). So far, in addition to medication management, therapeutic communities, assertive community treatment, dialectical behavioral therapy, exposure therapy, and integrated group

therapy have proven to be the most promising treatment approaches to individuals who are dually diagnosed (NIDA, 2010).

It is not difficult to comprehend why a person with a mental health disorder might want to self-medicate with drugs or alcohol, if only to temporarily escape the reality of living on the street, to calm the voices inside their head, to make them happy when all they feel is hopelessness and despair. Regardless of the reason that the individual chooses to become a drug user, this only adds another complication to their already complicated life as long-term drug use tends to perpetuate a cycle that is often characterized by non-medication compliance, homelessness, and treatment resistance in general (NIDA, 2010). In addition to these negative side effects, drug use creates a further barrier between the individual and friends and family who would normally be willing to help their loved one at any cost.

Because mental health professionals have been aware of the barriers to treatment within this population, many different types of outpatient programs have been designed to pick up where inpatient psychiatric hospitalization leaves off, with the hope of maintaining gains achieved while in the hospital and continuing to make progress with symptom reduction and maintenance and assimilation back to normal life. Some of these programs, although certainly not an exhaustive list, are partial hospitalization programs, assertive community treatment programs, community based mental health centers, intensive outpatient programs, private practitioners, and, as our society continues to progress, even telemental health services. Outpatient mental health treatment is important for many reasons. Pfeiffer et al. (2012) found that in the 30 days after an individual is discharged from an inpatient psychiatric hospital, suicide rates are more than 100 times higher than that of the general population. With information like

this, it would make sense to place a high value on ensuring that these individuals are linked with appropriate services, and more importantly, that they can access these services.

The fear is that many individuals do not receive outpatient mental health follow up treatment, despite the fact that it is clinically indicated. Without this critical follow up component, these individuals are left to figure out and arrange the next step of their treatment, which many of them are not capable of doing independently, or may feel is unnecessary. Pfeiffer et al. (2012) found that 10-15% of individuals who are discharged from an inpatient psychiatric hospital are readmitted within 30 days of said discharge.

As mental health professionals, we have a responsibility to our clients, our loved ones, and our community, to provide the most effective treatment available. We cannot just sit back and watch members of our community suffer as they are forcibly caught in the revolving door of mental health treatment. We must make an effort to understand what factors contribute to this phenomena, and step in to create programs and redesign existing treatment modalities to ensure that these individuals get appropriate care.

Definition Of Terms

Family estrangement. As it pertains to this particular study, family estrangement will be defined as both the emotional and physical separation, or distance, placed between an individual and at least one member of their identified family. To better understand the underlying issues associated with family estrangement, it seems appropriate to look at this phenomenon from three different perspectives: those of the identified patient, the estranged family member(s), and the clinicians involved in the patient's care. The causes noted for family estrangement will no doubt vary drastically for each family and it can be assumed that differences will emerge across the board depending on whose perspective is being taken into consideration at the time.

Mgutshini (2010), interviewed individual mental health consumers, in addition to professionals in the field, and solicited their feedback in many areas to compare and contrast attitudes, as well as highlighting similarities and differences of opinion. One area worth pointing out was how strongly consumers underscored poor access to social support and the actual break down of family relationships as a contributor to relapse or future hospitalization. Consumers also highlighted the importance of non-adherence to medication programs, self-medication with drugs and alcohol, family fatigue, exhausting of financial resources, mistrust in all directions and lack of communication.

A major theme highlighted in the literature, and presented well by Mgutshini (2010) is that hospital readmission is perhaps more of a learned behavior than it is medically necessary. Mgutshini (2010) suggested that one of the main motivating factors behind an individual seeking respite within the walls of a psychiatric facility would be to escape "the pressures of life." In addition, it was suggested that these individuals might also be looking to avoid certain high stress familial relationships.

There is a contradictory view presented in the literature, however. Menezes et al. (1996) and Quirk (2003) claim that close to 20% of psychiatric hospital admissions are involuntary, leading one to conclude that being readmitted to the hospital is not a learned behavior.

Hospital readmission. As it is used through out this discussion, the term 'readmission' will refer to an individual being admitted to an inpatient psychiatric hospital following a previous inpatient hospitalization (partial hospitalization is not included in this current discussion). The length of time in between discharge and re-admissions is not a specified requirement in this study, so long as it is characterized by a discharge and a separate admission. In addition, the admission does not have to occur within the same facility or for the same reason/behavior.

Exploring and coming to a better understanding about some of the basic causes that are so deeply rooted in treatment readmission is important for many reasons. Such insight might illuminate cost effective ways to adapt existing treatment programs to better meet the ever-changing needs of mentally ill individuals, their families, and society at large. Additionally, understanding gaps in the current system might lead to the introduction of new programs that are more relevant to life in the world outside locked hospital doors. To develop and focus such programs would require working collaboratively with mentally ill individuals, their family members, and professionals to better understand where they feel that treatment stops being effective and maladaptive behaviors begin again, hence leading to another admission.

In addition to the struggle to implement effective outpatient programs to address mental health needs within the community, continuity of care must also always be considered when designing such programs. For mentally ill patients who are hospitalized in an acute setting, the time spent in the hospital is critical. The goal of treatment on inpatient psychiatric units is crisis stabilization, getting acute symptoms under control, and allowing for assessment of the individual and appropriate triage to lower levels of outpatient care. Whatever treatment options that are discussed during this time, medications that may be started or modified, or goals that are set, should inform discharge planning as well.

Family members assume that when their loved one is admitted to a psychiatric hospital, it is because they are in desperate need of mental health treatment. Family members also assume that their loved ones are being cared for by the highest trained professionals in the field who have nothing but their loved one's best interests in mind. Family members adopt this way of thinking, in large part, due to the fact that they are given extremely limited information once their family member is admitted to a psychiatric hospital (Dixon et al., 2001). Family members

often admit that although they may know their loved one well, and can recognize when they are not doing well, they are not mental health professionals. With this being said, they trust that the treatment being provided behind the locked doors of the hospital are going to help cure their loved one, keep them safe, and help transition them back to their daily life. Increased family involvement would aid in said transition. Research conducted in the 1990's and 2000's indicates that mentally ill individuals have better outcomes, post psychiatric hospital discharge, if the needs of their family members are addressed and met, specifically referring to information regarding their loved one, as well as education and clinical guidance (Dixon et al., 2001).

One of the main problems is the limited time mentally ill patients actually spend in an acute inpatient hospital setting. As Mgutshini (2010) highlights, there has been a huge paradigm shift in mental health care over the last 25 years and how services are delivered in the United States. This is particularly evident when looking at how provisions have moved from hospital-based care to community-based alternatives. Blader (2011) highlights that since the 1990's, payers (e.g., insurance companies) have made it more difficult for individuals to secure lengthy hospital stays through more rigid admission and continued stay criteria, in addition to lower reimbursement rates. This causes acute care settings to discharge individuals sooner, rather than later.

In light of economic constraints and resistance from most insurance companies, hospital administrators are required to focus solely on crisis stabilization and discharge planning. Insurance providers demand daily updates from case managers and psychiatrists regarding their client's current mental health status. Once they are no longer deemed an immediate threat to themselves or someone else, or can essentially articulate a viable plan for self-care, however basic it may be, the insurance providers are pushing for discharge and denying further approval

of payment (Medicare Psychiatric Patients, 2013).

It would seem, in the long run, that it would not only be more beneficial for seriously mentally ill patients to receive prolonged treatment (when clinically appropriate) at the inpatient level, but more beneficial for insurance providers as well, since thorough treatment the first time around would seemingly decrease the need for future hospitalizations. Although a client may be stabilized and no longer actively suicidal after 72 hours on an acute unit, he or she may still be benefitting from the treatment being provided in that setting.

Addressing hospital readmission requires that professionals in the field and both mentally ill patients and their family members alike work together in order to better understand where treatment is lacking, how it can be improved and what alternatives exist in place of hospitalization in the event that a future crisis occurs.

Resilience. To say that one is resilient is also to say that one is strong in mind, determined to overcome whatever obstacles have been placed before them, and flexible in their thinking. Resilience occurs when, despite being struck by tragedy, loss, and trauma, growth and change are developed from within an individual. Marsh et. al (1996) define resilience as "the ability to rebound from adversity and prevail over the circumstances of our lives ."

In the beginning stage of a crisis, perhaps when a family is considering hospitalization for a loved one, there is likely an overwhelming surge of emotions, most of which can quickly be identified as negative. Stewart (1984) identified the first stage of his model for building an alliance between the family and institution as the crisis stage. In this stage, Stewart (1984) suggests that family members will experience emotions ranging from guilt to a loss of self-esteem. However, research has shown that families, as well as individuals, have the innate ability to heal after being struck with tragedy. At times they are not only able to heal, but to overcome

the tragedy victorious, with better insight, a heightened ability to empathize with others, and a road map on how to proceed when future tragedy strikes (Marsh et.al, 1996).

Along the same lines as Marsh et.al, Choler (1987) examined resilience as it specifically relates to children. He described resilient children as being better able to cope with the negative effects of adversity and to be more likely to reach out to others for support. Because mental health treatment has shifted so dramatically, with its focus going from hospital-based care to community-based care, family plays a bigger role in providing said care (Foster, O'Brien, & Korhonen, 2012). Within the concept of family are the children. This is important to pay attention to because research suggests that when a child has a parent with a mental illness, they are more likely to develop psychosocial problems of their own (Foster, O'Brien, & Korhonen, 2012).

Most people familiar with chronic mental illness would describe it as a terrible disease for the individual inflicted with the symptoms. Some know it well enough to say that mental illness is characterized by a set of negative behaviors and repetitive events, such as hospitalizations, that have detrimental effects on the entire family (Anthony, 1970). For the most part, this view holds true in most mental health treatment facilities as well, as evidenced by treatment programs that are focused almost solely on the individual, excluding family members who would like to be willing participants in their loved ones' journeys.

It is presumed that family-inclusive treatment, along with a positive viewpoint of recovery, including fostering the belief that things will get better and focusing on resilience as opposed to failure, would result in an increased likelihood of treatment maintenance and have overall positive effects for all involved. Research conducted by Dixon et al., (1970) suggests that when family members of a mentally ill individual are provided with psychoeducation, as

opposed to cases in which only standard individual treatment was provided, the individual

demonstrates reduced rates of psychiatric hospital readmissions. As a result of this evidence,

some treatment teams began to include family education as part of standard treatment protocol

(Dixon et al., 1970). One research program in particular, the Schizophrenia Patient Outcomes

Research Team (PORT), added psychoeducation for the entire family to its recommendations for

treatment. Specifically, PORT suggested that families who are in contact with a mentally ill

relative should be offered family psychosocial interventions, such as education surrounding

mental illness, family support, and crisis intervention, among others, for a minimum period of

nine months (Lehman, 1998).

Subjective and objective burden. One of the reasons that chronic mental illness is

viewed as such a tragic and life-changing condition is partly due to the research, which strongly

emphasizes the overwhelming negative effects on the individual and their loved ones. Marsh

et.al (1996) pointed out that families shift from what once was a normal routine to new and

daunting experiences to be blindly navigated. The authors characterized these experiences as

subjective and objective burden.

Subjective burden can be understood as the negative feelings experienced by the family

members of an individual affected by mental illness. Greenberg et.al. similarly define subjective

burden as "the personal suffering experienced by family members in response to the mental

illness of their relative (1993)." Subjective burdens rise from many different experiences; thus it

would be difficult to put limitations on specific examples, as they may be different for every

person. There are, however, some experiences of subjective burden that are commonly

experienced by family members. Some of these components include the empathic pain that they

feel as a direct result of watching their loved one suffer, lasting sadness as the disease impacts so

many people other than the identified patient, and the unpredictable course that the illness may take through-out a loved one's life.

Family members often experience something known as objective burden, which is based around the problems that arise on a nearly daily basis. Some of these problems include, but are not limited to, the constant caregiver stress that often accompanies a loved one's diagnosis; reactions to symptoms or behaviors, such as fear related to a loved one's paranoia and abnormal behavior; and frustration with a lack of resources, treatment, and the mental health system in general (Marsh et.al, 1996).

Purpose of the Study

The purpose of this study is to investigate the underlying causes for inpatient psychiatric hospital readmission. This study aims to provide crucial information regarding variables that treatment programs can utilize in providing adequate patient care and improving continuity of care post discharge. Specifically, this study seeks to provide information that will aid treatment programs in implementing earlier stage interventions and support for individuals throughout their journey with mental illness. This study aims to correlate rates of readmission to psychiatric inpatient settings and family estrangement. This study will also take into account the covariates of substance abuse and demographic information with readmission.

Significance of The Problem

Why is this so important? The importance of this study lies in the facts. According to data from the National Alliance on Mental Illness (NAMI), the impact that mental illness has on our country is profound. For example, NAMI reports "depression is the leading cause of disability worldwide, and is a major contributor to the global burden of disease." NAMI also brings to light the cost of mental illness in America: $193.2 billion in lost earnings annually,

beyond the profound direct costs of care. What's even more sobering than the cost of mental illness to our country is the heartbreaking reality that close to 60% of adults suffering from a serious mental illness did not receive any type of treatment in the last year (NAMI, 2014).

As individuals, as family members, as concerned citizens, professionals, and researchers we must do all that we can to figure out why services are not being accessed and/or utilized. Are there not enough treatment centers? Is the stigma around receiving treatment too unbearable? Is treatment affordable to the consumers? Are we involving the right people in the care of individuals with mental illness? Is our funding going to corrections or treatment? Do the patients even believe that they have problem that would motivate them to obtain, and actively participate in, treatment?

The research obtained from this study is important because of the positive implications that may arise from it, including, but not limited to, early intervention and detection programs, peer-led support groups, workshops for family members, education for the entire family, and support in the form of wrap-around services in which families can receive services and support in their home, in addition to any other outpatient treatment that may be simultaneously occurring.

In addition to the positive implications illustrated for the individual and their family, findings from this research may also lead to strides being made in the area of fiscal management, which, in turn, would not only benefit the consumers and their family, but also the community as a whole. Despite the existence of after-care programs for individuals who have been released from inpatient psychiatric facilities, there is still an overwhelming number of individuals who do not utilize the services that are being offered to them and continue to seek treatment at the inpatient level of care when they are no longer able to function normally.

If family estrangement is correlated to inpatient psychiatric hospital readmission, mental health professionals may utilize this information to implement programs designed to be more inclusive of families through-out the therapeutic process. With extended support from family members, an individual is more likely to adhere to ongoing outpatient mental health treatment, including medication management and attendance of educational and support groups.

In Western society, treatment is based primarily on a medical approach focused almost entirely on the individual patient, leaving out the family nucleus; despite the fact that oftentimes individuals have concerned family members who are willing to help and desperately seeking the knowledge they require to effectively do so. Without further research into the correlation between family estrangement, including the objective and subjective burden that chronic mental illness has on families, mental health professionals are not able to appropriately initiate programs incorporating the needed services; a lack of knowledge compromises their efficacy.

Research in this area has the capacity to initiate a major positive shift in the long-term treatment of chronic mental illness from previously held views of intense treatment at the time of a crisis and low-level maintenance of symptoms, to earlier detection, intervention and prevention of symptoms, as well as models of treatment based on recovery and resilience.

With individuals and family members often left feeling burned out after periods of crisis, especially when they have led to an inpatient hospital admission, there is often a sense of a lack of support and little access to information on how to obtain the next level of care. This is in large part due to psychiatric hospitals performing absolute discharges, which entail little to no follow up. Another factor contributing to burn-out is the family being left out of the treatment-planning phase. One must take into consideration whether it's due to the client's insistence on maintaining confidentiality or simply information not being shared by the social workers who coordinate the

discharge planning. Either way, this data could lead to mental health policy changes as they pertain to the inclusion of family members as vital to the recovery process, as well as better training for mental health staff who are in direct contact with the consumers.

What can this data do for patients and treatment programs? For the purpose of this study, it is assumed that early diagnosis of mental health issues, coupled with education of symptoms and treatment, and wrap-around support for the entire family, would not only increase participation in ongoing outpatient mental health treatment, but also decrease readmission rates within inpatient psychiatric hospital settings. For a multitude of different reasons (reasons that are discussed further elsewhere through out the paper), individuals who suffer from severe and persistent mental illness are not utilizing the resources that are made available to them. Resources being the various levels of outpatient treatment that might include individual and group therapy, medication management, life skills training, and substance abuse treatment.

Thus far, there is more data surrounding the importance of early detection and intervention of mental illness, as well as treatment and stabilization, than how to successfully get individuals to comply with treatment. For the purpose of this study, although the inclusion of family members in an individuals' treatment is regarded as highly beneficial, opposing views must also be considered. Despite the fact that Stewarts' (1984) research on family involvement at the inpatient psychiatric hospital level of care confirms that the alliance between the family and the institution will lead to improved outcomes for the patient and lower rates of inpatient psychiatric hospital readmissions, it is also noted that Kaas et al., (2003) encourages professionals to consider that family involvement in an individuals care could also be experienced as having harmful effects on patient improvement, in the sense that family members can also be a contributing factor to the individuals' symptoms.

Mental health professions must determine that the familial relationship is more beneficial than harmful when deciding to include family in an individual's treatment. The more mental health professionals understand the pivotal role of family involvement and accept the challenge of including said families in treatment, the closer we are to providing effective and client centered care.

Research Question And Hypothesis

This study will examine the relationship between family estrangement and hospital readmission rates among adults within the inpatient psychiatric hospital setting. The hypothesis is that when an individual is estranged from his or her family or support system, the likelihood of inpatient psychiatric hospital readmission will be greater compared to an individual who has a healthy support system of family and/or close friends. Without family support, an individual is more likely to struggle with medication compliance, access to and utilization of outpatient treatment and issues surrounding self care (Heslin & Weiss @015).

The interest for this study arose during time spent on the case management unit of an inpatient psychiatric hospital. Within the first month, it became alarmingly clear that the same individuals were coming back to the hospital. It was unclear as to whether or not these individuals were being readmitted because of the severity of their illness, because their previous admission was unsuccessful in treating their mental health issue, because they had no other coping skills or support to utilize once integrated back into life outside of the hospital, or because they actually felt secure and enjoyed being in the hospital.

Because there is not a lot of literature connecting the piece of family estrangement and psychiatric readmission rates, this study will shed light on the importance of having a strong support system within one's own family unit. It is the hope that if a correlation between family

support and decreased inpatient psychiatric hospital admissions exists, that mental health providers would be more inclined to include the family unit in all stages of treatment. At this point, most family members would report that they are rarely included in the treatment process regarding their loved one, be it attributed to lack of time spent in the hospital, diminished resources, or laws that protect an individuals personal health information, such as the Health Insurance Portability and Accountability Act (HIPAA).

Stewart (1984) highlighted the importance of building an alliance with the mental health institution and the individuals family for many different reasons including, but not limited to: the idea that a "family presence" is related to effective outcomes, the act of inpatient psychiatric hospitalization itself represents a family crisis and generates intense feelings for everyone involved, and also because distant, competitive and enmeshed families can create difficulties for staff.

Chapter II Literature Review

According to research conducted by the National Institute of Mental Health (NIMH, 2015), the number of adults living with a mental health disorder in America is 1 in 5, about 43 million people. Of these 43 million Americans, it is estimated that almost 10 million of them suffer from severe symptoms that impair their functioning in their daily life (NIMH, 2015). The distinction being made by NIMH is that not all individuals who suffer from a mental health disorder are considered disabled. Instead, a person is considered disabled when their symptoms impair their ability to execute tasks required of them to function independently on a daily basis. For example, they are not able to get to the store to buy food. This data reflects the same numbers put out by NAMI in 2016.

According to NAMI (2016), research indicates that 43.8 million adults are faced with a mental health problem in a given year (which is 1 in 5). NAMI goes on to report that, of these individuals affected by mental health problems, 10 million of them (1 in 25) are diagnosed with a "serious mental illness" (2016). Also in sync with research published NIMH, NAMI (2016) reported that "one-half of all chronic mental illness begins by the age of 14; three-quarters by the age of 24."

Interesting research conducting by NIMH (2015) shows that 20 percent of adolescents, ranging in age from 13-18, currently have, or have had in the past, what is considered to be a serious mental health diagnosis. These numbers are considerably high in comparison to the 8.3 percent of adolescents who in this age range who suffer from asthma, and a low 0.2 percent who have diabetes (NIMH, 2015). With data like this, it seems imperative to not only review studies that have already been done regarding mental health treatment, but to also begin to develop new treatment that is both beneficial and cost effective.

Specifically regarding cost surrounding the treatment provided to those with a mental health disorder, The Substance Abuse and Mental Health Administration estimated that the cost of treatment for individuals within the mental health care system was 147 billion dollars in 2009 (Insel, 2008). According to Insel (2008), this number was projected to be 467 billion dollars in America in 2012. Along the lines of treatment costs for mental health disorders, disability is something that is tracked closely as well.

The Global Burden of Disease study came up with a single disability number, known as DALY (disability-adjusted life years), to help categorize all 291 injuries and conditions that were assessed. "The DALY score combines years of life lost to premature mortality and years lost to disability attributable to each condition" (NIMH, 2015). This is extremely important to pay attention to considering that the single largest source of DALY's in America, across injury and illness categories, are brain disorders; which include, but are not limited to, mental, neurological, and substance abuse disorders (NIMH, 2015). Out of the 291 conditions and injuries assessed, major depressive disorder ranks number 5, with anxiety disorders ranked number 13 and schizophrenia following in rank at #27 (ranked in terms of DALY burden in America) (NIMH, 2015).

In addition to the DALY, the cost of lost earning in America is also researched. According to NAMI (2016), serious mental illness costs the United States over 193 billion dollars in lost earnings every year. This data is directly correlated to individuals requiring treatment for their mental health disorders, and takes into account available treatment options. According to NAMI (2016), almost 60 percent of American adults who suffered from a mental health disorder did not get treatment of any kind (this number for adolescents aged 8-15 is 50 percent). NAMI (2016) also reported that, sadly, African American and Hispanic American

individuals utilized mental health services

Organizations designed around promoting awareness and treatment of mental health disorders, such as NAMI, conduct research and provide alarming facts that one would imagine could not be ignored by legislatures and policy makers in this county. For example, according to NAMI (2016), 90 percent of individuals who successfully complete suicide have an underlying mental health disorder. Both NAMI (2016) and the Centers for Disease Control and Prevention (CDC, 2013) site suicide as the 10th leading cause of death in the United States for all ages, taking 41,149 lives. This number is comparable to the deaths attributed breast cancer, is six times higher than the number of lives lost to HIV, and is close to three times the number of homicides (CDC, 2013). What is equally as alarming as the suicide rates are the number of individuals who reported having suicidal thoughts and even began to plan their own death.

According to the CDC (2013), it is reported that an estimated 9.3 million adults in America (3.9 percent of the population) admitted to having suicidal thoughts in the past year, 2.7 million people (1.1 percent of the population) made a plan about how they would end their life, and 1.3 million people (0.6 percent) made a suicide attempt.

According to research done by Walker et al., (2015), it is estimated that the "median reduction in life expectancy among those with mental illness was 10.1 years." Some of the causes associated with this early mortality rate are noted to be 'natural causes' such as acute and chronic co-morbid conditions; including, but not limited to, heart, pulmonary and infectious diseases (Walker et al., 2015). What is most astonishing about their research is that they were able to conclude that 8 million deaths occur each year (roughly 350,000 death in the United States annually) that could be avoided if individuals with mental health disorders died at the same rate as the general population (Walker et al., 2015).

Role of Social Support

A theme that is prevalent throughout a lot of the literature on severely mentally ill adults and their treatment is the role of family involvement, or other social support. Family members appear to play an important role in the lives of their loved ones suffering from a serious mental illness. Often times, they are not only providers of emotional and financial support, but they also take on a strong advocacy role, provide case management and housing (Dixon, et al., 2001).

Before reviewing the role that social support has on an individual's recovery, it would be prudent to first understand how social support is defined and measured. Different researchers have postulated various theories on social support and it's role on overall health and wellbeing. For example, Whitaker (1983) outlines how social support is born and nurtured in ones immediately family, circle of friends, neighbors, and in support groups created and maintained by an individual. Other researchers, such as Lin (1986) have taken the idea of social support a bit further by hypothesizing that it occurs on more than one level. Lin (1986) stated that how one connects to their own social environment is critical and can occur on three different levels: (1) the community level, in which an individual is integrated into their own unique community by means of social learning and integration (2) the social network level, which occurs across many different social interactions, and (3) the level of intimate relationships, in which individuals might seek advice and comfort surrounding their personal life and share private feelings.

Going a step further in understanding the role of social support, it is critical to note that buy in from the individual is necessary. This means that a person may have support being offered to them, however, they lack the interest in receiving said support or do not feel that the support being offered is actually attainable or useful to them. Streeter and Franklin (1992) go in to detail about this conceptualization of social support and refer to it as 'perceived social support.'

Streeter and Franklin (1992) describe perceived social support as an individual's assessment and understanding of their relationships and connections to other people or entities.

The notion of perceived social support acknowledges that the mere suggestion that an individual be linked with someone or something in their community does not necessarily result in the development or maintenance of social support (Streeter & Franklin, 1992). Some reasons that an intended social support might not become an actual perceived social support include efforts that are against the wishes of the individual, badly timed, or flat out inappropriate (Streeter & Franklin, 1992). For example, upon discharge from a psychiatric hospital, an individual might be less likely to perceive social support as being beneficial to them if the discharge planner doesn't include them and their family in the planning process, or if they are referred to an outpatient clinic on the other end of town when they lack transportation. It is imperative that an individual believe that the support being offered will be available to them when they need it and will be enough to meet their needs, otherwise, there would be diminished likelihood that they maintain a connection to such support (Streeter & Franklin, 1992).

Looking at social support from a rudimentary standpoint, there are different types of support. Pattison (1977) suggested that there are two basic types of support, instrumental and affective. According to Pattison (1977), instrumental support includes discernable support, such as financial aid and materials, where as affective support includes emotional support and social reinforcement. Although Pattison provides a great description for two basic types of support, other researchers have presented conceptualizations that are more precise. For example, Barrera and Ainlay (1983) developed a construct for understanding social support based on categories that were reoccurring through out their research. Barrera and Ainlay (1983) identified six categories of social support: (1) Material support, such as money or tangible objects, (2)

Behavioral assistance which they defined as "sharing of tasks through physical labor," (3) Intimate interaction, modeling behaviors such as listening, expressing empathy and understanding, (4) Guidance, in which instruction or advice are offered, (5) Feedback, in which individuals are provided with comments and observations regarding their behaviors, thoughts and feelings, and (6) Positive social interaction, in which individuals engaged in activities meant to be fun and relaxing in a social setting.

Vaux (1988) recognized the work done by Barrera and Ainlay and stated that their categorization of social support accurately reflects related literature. Vaux (1988) went on to praise the work done by Barrerra and Ainlay (1983) by reaffirming that each category had a corresponding description that provided thorough examples of behaviors associated with each type of support. Streeter and Franklin (1992) offer an equally important observation, however, respectfully suggest that what was described by Vaux (1988) as a strength, can also be viewed as limitation of the duos work. According to Streeter and Franklin (1992), while the descriptions within each category focus on supportive activities, they fail to mention the role of the individual's personal assessment of such support, as well as overlook possible consequences to the outlined activities. Streeter and Franklin (1992) describe social support as complex and stress the importance of understanding the influential role it plays in daily functioning.

Although not as common as the study of social support alone, social support, and its correlation with mental health treatment, specifically readmission to inpatient psychiatric hospitals, is emerging in the literature. Ossman and Mahmoud (2012) studied the relationship between social support and the length of stay in a psychiatric hospital among schizophrenic clients. Ossman and Mahmoud (2012) summarized the negative impact that long-term hospitalization can have on an individual, one of such impacts being that the longer an individual

is hospitalized, the more isolated that person becomes from their support system. Ultimately, this has led to pressure being put on psychiatrists to shorten length of stay.

Ossman and Mahmoud (2012) point out that social support is something that is far to often absent in the lives of mentally ill individuals. They summarized that research has found that individuals with mental illness, specifically schizophrenia and related disorders, are far more socially isolated than someone in the general population. In comparison with individuals who do not suffer from a mental illness, individuals with schizophrenia have smaller social networks and the networks that they do have are often limited to family. Ossman and Mahmoud (2012) reported that individuals with schizophrenia bear extremely dismal outcomes as a result of limited social support, including a poor quality of life, more psychotic symptoms, and more frequent and prolonged admissions to psychiatric hospitals. Supporting the research done by Ossman and Mahmoud, another study found that individuals who have a larger system of social support are hospitalized less often, if at all (Cechnickim, 2007). Ossman and Mahmoud (2012) reported their findings that suggest that the longer an individual spends in a psychiatric hospital, the more their connection to social supports in the community dissolve. To make matters more of a challenge, individuals who suffer from the negative symptoms of schizophrenia, such as becoming withdrawn and maintaining a blunted affect, struggle more with maintaining a strong social support system as their symptoms interfere with their ability to connect with others.

Research done by Anthony (1970) highlights the impact that mental illness has on the entire family unit. He speaks to the fact that when a loved one has a 'major crisis' or episode with their illness, families that are better organized and integrated are going to cope better and bounce back quicker from the problem at hand. However, Anthony J. also pointed out that with repeated crisis among the mentally ill and their family, the ability for the family to function

cohesively is impaired. Jamison (1999) highlights certain risk factors that tend to increase symptoms and suicide attempts in mentally ill individuals. On his list was lack of support and involvement from friends and family.

History of Psychiatric Hospitalization

Through out history, and across all different cultures, mental illness has existed among individuals; both old and young, rich and poor. What has changed through out the years, however, is how mental illness, specifically treatment of such, is handled in various communities and cultures. For example, in ancient Greece and Rome, it was expected that family or close friends would care for mentally ill individuals; this was referred to as the burden of care (Meyer and Weaver, 2006). As all things do, this expectation evolved. In the 16th Century, the government initiated civil commitment. At this time, however, civil commitment was not designed to treat the inflicted individual; instead, it was used to get "undesirable" individuals off of the street (Meyer and Weaver, 2006).

Meyers and Weaver shine light on a particular Supreme Court case that is seen to have led to the establishment of legal precedents that are still in use today (2006). The case of *In re Oaks* (1845) documents the story of an elderly man, Mr. Oakes, who resided in Massachusetts, and was taken to the McLean Asylum in Belmont by his family against his will. The family maintained that he was 'pathological,' and despite objecting to the treatment, the facility refused to release him. Mr. Oakes eventually petitioned his case and was heard by the Supreme Court, who ultimately ordered him to remain confined. Although Mr. Oakes may not have seen the benefits of his appeal, birth was given to four precedents that were required to be upheld, or recognized, moving forward.

First, it was determined that the state had a right to commit an individual to a facility against their will. Second, it was assumed that family members of the ill individual would serve as decision makers for their treatment, including length of stay. Third, it would be recognized that the due process for civil versus criminal matters is different. And finally, it was clarified that while involuntary detainment was put into effect, initially, to keep the public safe from dangerous individuals, that the individuals own welfare was also a consideration (Meyers and Weaver, 2006).

Meyers and Weaver highlight a couple of key implications of the Oakes ruling that were seen to be moving away from mentally ill individuals having rights surrounding their treatment. (2006). Meyers and Weaver first present the view, which was upheld by the public at the time this case was being heard, that mentally ill individuals lack free will; which rationalized the further practice of not giving these individuals due consideration to their wishes (2006). Meyers and Weaver also describe how this case paved the way for paternalism, which allowed family members and professionals amongst the field to make decisions about the individual and without their consent (2006).

Of course, it seems apparent that even though this is not the wide held view of family members, researchers and professionals today, these precedents were developed with the inflicted individuals best interest in mind. What was not taken into account at this time, however, was the fact that it was only presumed that concerned family members and professionals would be acting in the persons best interest. The reality, however, was that individuals were often committed for things that were more socially frowned upon that actual pathological (Meyers and Weavers, 2006).

When antipsychotic medication became more effective in the 1950s and 60s, another shift in the treatment of mental illness also occurred, reverting back to the practices of ancient time, when family was the main source of support and care giving (Meyers and Weaver, 2006). Meyers and Weaver go on to discuss other trends surrounding treatment for mental illness that were moving away from civil commitment (2006). These trends were changing with the times and adapting to the movements set forth by activists in the field, such as the civil rights movement.

Meyers and Weaver (2006), in conjunction with Amador (2012), postulate that the development of laws surrounding the detainment of mentally ill individuals through out history has helped shape current treatment practices in the field, without such laws in places, who knows what shape mentally ill individuals, their families and their communities would find themselves. With that being said, these researchers also admit that there are still flaws in the way that the law is applied. While Amador acknowledges that the laws outlining the implementation of mental health treatment are necessary, he recognizes that each individual is unique and will require a treatment plan to fit their needs. Just because inpatient hospitalization had benefits for one individual, does not necessarily indicate that everyone with a mental illness will improve or recover with the same type of treatment or intervention. Amador implores that professionals in the field should be aware and educated surrounding the important role that psychiatric hospitalization can play in saving the life of an individual; however, he suggests that it not be taken lightly and to exhaust all other treatment options first (2012).

Contrary to some of the more historical beliefs surrounding individuals with mental illness and their ability to make their own decisions regarding treatment, society currently finds itself in the midst of a more client empowered era, in which family members and professionals

are encouraged to support the individual in making their own decisions regarding mental health. Currently, societal norms indicate a wide held stance promoting deinstitutionalization, meaning that individuals should only be committed against their will when all other, less restrictive, interventions have been exhausted (Corey, Corey, and Callanan, 2007). Amador describes how family members and professionals, alike, are more hesitant to pursue involuntarily commitment today. This is likely due to several concerns, one of which being of the potential risk of damaging the trust in the relationship that has already been established (2006). It is conceivable that another hesitation amongst professionals when considering psychiatric hospitalization is driven by their desire to protect themselves, legally. With that being said, although societal beliefs are rooted in wanting to support an individual in their right to seeking (or decline) treatment, the practical application of mental health treatment often does not support this supportive relationship. Amador reported that the current mental health system "is set up to put a wall between mental health professionals and their patients' families (2012, p175)." h

In the United States, each state has passed legislation surrounding civil commitment of an individual who presents as a danger to themselves or others. Just as it is with the penal system, each state has set forth different criteria that might warrant treatment of individuals presenting with these safety concerns. Meyers and Weaver bring up an important flaw in the states legislature, that being that there is nothing concrete governing those individuals who may not be a danger to themselves or someone else, however, are clearly suffering from symptoms that warrant intervention (2006).

The current standard required to provide minimally adequate mental health treatment to individuals with serious mental illness is 50 inpatient beds per 100,000 individuals (Treatment Advocacy Center, 2016). Similar to the other 49 states in America, California fails to meet this

requirement. Data published by the Treatment Advocacy Center suggests that the number of available beds in California in 2010 was 5,283, 622 less beds than the reported 5,905 that were available in 2016 (2016). However the number of beds per 100,000 individuals was a dismal 15.1 (Treatment Advocacy Center, 2016).

Although not rampant through out the research, the case against preventing suicide merits discussion. It is often assumed that mental health professionals operate under the guidelines of taking whatever steps necessary, within legal and ethical bounds, to prevent an individual from committing suicide. Szasz (1986) presents an alternative view that recognizes suicide as an individuals right, which challenges coercive methods used to prevent such an act, such as involuntary hospitalization. Szasz (1986) supports his non-traditional view by claiming that mental health professionals often work in conjunction with law enforcement to assist in carrying out coercive measures when an individual refuses treatment. By doing so, these mental health professionals have marked themselves as enemies of individual liberty. The act of intervening when an individual has expressed the desire to end their own life, according to Szasz (1986), is depriving the client of their right and role of accountability in this decision.

Although some may criticize Szasz for his openness surrounding suicide as a individual right, it is imperative to clarify that he is not suggesting that suicide is good or that it should be considered a morally sound option for anyone experience suicidal ideation. Instead, his view supports the notion that having to use the power of the state to coerce an individual into treatment is going beyond the power given to us as individuals.

Initiating Psychiatric Hospitalization

In the United States, there are two ways that psychiatric hospitalization can be pursued; that is voluntarily and involuntarily. No matter the legal status of the pending hospitalization,

there are multiple routes that an individual can take to get to a hospital. These include, but are not limited to, going to an emergency room, involving law enforcement (and requesting a crisis intervention trained officer), or contacting the local crisis team (Amador, 2012). Many people with severe mental health problems seek treatment voluntarily, meaning someone else did not illegally initiate their hospitalization. Voluntary hospitalization generally indicates a higher level of insight and awareness on the part of the individual, with them recognizing and initiating treatment.

Involuntary psychiatric hospitalization, created with the intention of helping individuals suffering from mental distress, has been a controversial topic through the United States (Comer, 2004). There are strict laws in place guiding mental health professionals and law enforcement officers on the specific requirements that must be met in order to pursue involuntary psychiatric hospitalization. In California, the Welfare and Institution's Code 5150 provides guidelines regarding how to involuntarily detain an individual who is presenting as a danger to him/herself, a danger to others, or gravely disabled. According to the code:

> 5150. (a)When a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services.

These laws were put in place in accordance with each states duty to ensure the safety of unstable individuals, as well as the safety of all community members.

In his book 'I AM NOT SICK I don't need help,' Amador (2012) stated his preference that involuntary psychiatric hospitalization be utilized only as a last resort for treatment, as most mental health professionals would likely agree. Unless an individual is unable to remain in a less restrictive treatment environment, such as their own home or a residential treatment facility, as evidenced by decompensation that puts the individual at risk, threatens the lives of others, or leads to such extreme grave disability that the individual requires immediate intervention, involuntary hospitalization may not be the most effective treatment available at the time.

According to Feifel (2008), hospitalization is "a declaration that a patient's clinical status has become so dire that attempting to manage his or her disease on an outpatient basis is either infeasible or too risky." Feifel (2008) and Amador (2012) agree that the main psychiatric hospitals serve the main purpose of maintaining an individual safely and securely.

Jamison (1999) proposed that clients, family members and mental health professionals think carefully when considering treatment options, especially for individuals who are suicidal. In his book 'Night Falls Fast,' Jamison acknowledged the stigma surrounding inpatient psychiatric hospitalization and how much this can impact decision-making in regard to treatment, including considerations of financial burden, and professional repercussions. However, he also reminded readers that hospitals not only save lives, but provide relief, even if only temporarily, to concerned friends and family knowing that there loved one is in a safe place. Jamison (1999) suggested a subtle shift in the way hospitalization is viewed. Instead of seeing it merely as a last resort treatment option or a failed attempt at managing symptoms in alternative

treatment settings, he characterized psychiatric treatment as an option that might be necessary on an occasional basis, in order to help treat serious and persistent problems (Jamison, 1999).

Amador (2012) brought to light the reality that although psychiatric hospitalization can be helpful for individuals suffering from mental health problems, even keeping them alive, hospitalization can be experienced as traumatic for others, causing more harm than benefit in the long run. It is for this reason that people cannot be detained against their will unless probable cause to do so exists. In California, the code defines probable cause as the following, which is based on Supreme Court Case People v. Triplett (1983):

> Facts known to the authorized person that would lead a person of ordinary care and
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> prudence to believe, or to entertain a strong suspicion, that the person detained is
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> mentally disordered and is a danger to him or herself, or others, is gravely disabled

The goal of the assessment is to determine the most appropriate level of care that the individual requires in order to have their needs met. Coming to an informed decision regarding level of care depends on the individual's unique circumstances, what collateral information is available at the time, the person's protective factors and, probably most importantly, their current risk factors. When the individual's symptoms can no longer be managed in a less restrictive environment, psychiatric hospitalization may be necessary.

Once determined that psychiatric hospitalization is necessary, it is important to educate the client, and any friends or family who might be involved in their care, on what to expect from this type of treatment facility. Inpatient psychiatric hospitals are designed to keep individuals safe and to stabilize acute symptoms. They are not intended to be long term treatment programs and once the individual is no longer considered to be a danger to self, others, or gravely disabled, discussion of lower levels of care and discharge planning take effect.

From the perspective of the individual receiving services, being admitted to a psychiatric inpatient facility multiple times within a 12-month period is often associated with feelings of extreme despair and shame (Mgutshini, 2010). This tends to disrupt the individual's normal pattern of daily living, often leading to feelings of hopelessness, helplessness, and an increased risk for suicide (Mgutshini, 2010). Without the psychological and emotional needs of these individuals being met, their perceived symptoms may continue to worsen.

When an individual feels backed into a corner and senses that they have no access to otherwise effective coping skills, they are going to revert back to behaviors that once made them feel better. For many, that was the last time they were in the hospital.

Typically, when an individual enters a psychiatric inpatient facility, they are in a state of extreme crisis. By the time they leave, it is the hope that they are stabilized, whether through medication or learned coping skills, and are functioning close enough to their baseline to get back out into the world and function as they once were. Hence, it comes as no surprise that Appleby et al. (1996), Hurt (2001), and Thompson et al. (2004) have noted that the most reliable indicator of future risk of hospitalization is 'history of repeated admissions." After all, past behavior is the best predictor of future behavior.

Initiating hospitalization is often falls in the lap of mental health professionals, including psychiatrists and psychologists. The only flaw in placing so much expectation on these professionals, according to Jamison (1999) is that these professionals are not immune to the illnesses that they treat. In fact, research suggests that doctors in the mental health field are twice as likely to commit suicide compared to the general population. Within the mental health profession, psychiatrists are especially susceptible. Looking further into the data, it is known that

women doctors are three to five times more likely to commit suicide, compared to the general population (Jamison, 1999).

Family Estrangement

When an individual is diagnosed with a serious mental illness, it is not only catastrophic for that person, but for the entire family. As a result of the diagnosis, and the course that illness follows thereafter, the family members share in what Marsh et al. (1996) refer to as the subjective and objective burden.

The subjective burden, described in more detail by Greenberg et al. (1993), can be understood as the personal suffering experienced by each family member in response to the diagnosis of their loved one. A major component of subjective burden is the often-difficult task of the family of learning to expect different things from their loved one- essentially, mourn the loss of the person that they once knew, and to accept the new person that is sitting in front of them. This grieving process can either strengthen a family unit, or expose all of their weaknesses causing a breakdown in communication and eventually leading to estrangement.

In addition to subjective burden, family members are also forced to cope with issues of objective burden; simply put, the daily problems that come along with the diagnosis that now follows their loved one around wherever they go. Family members have to learn to deal with the symptoms of their loved one's illness, as they will inherently have an impact on their lives as well. In addition to the symptoms of the mental illness, Marsh et al. (1996) describe objective burden as including things such as the family members needing to learn to cope with bizarre behavior and/or violence, becoming a caregiver, being caught in the often frustrating and limiting mental health system and so on. Hence, if a family is not equipped with resilience and

strong protective factors in place, their ability to deal with each mental health crisis that presents itself is going to going to diminish.

In recent decades, countless reports have been generated and papers written studying the impact that mental illness has on the functioning of family cohesiveness. The more often an identified patient becomes ill, or relapses, the harder it becomes for the family to get back to its state of homeostasis (Anthony, 1970). When studying family involvement, many researchers relied on face-to-face interviews with families of the identified patient. In addition to gathering collateral information through interview form, researchers also reviewed clinical notes from staff in various mental health treatment settings, including inpatient psychiatric hospitals.

Foster, O'Brien and Korhonen (2012) explored the pivotal role that mental health professionals play in the treatment of adults with severe mental health problems, as well as how their illness impacts the functioning of their children. Surprisingly, these mental health professionals, who ranged from nurses, social workers, psych techs, case managers and so on, felt they played in the recovery and wellbeing of these families. This could be due to a multitude of factors, including a lack of education in how to implement family-focused treatment. This was seen more often in inpatient settings, when the individual was in a state of crisis.

Foster, O'Brien and Korhonen (2012) noted that hospitalization is often conducted in a crisis mode in which attention is focused almost exclusively on the patient and the circumstances leading up to admission. Overburdened hospital staff members may struggle to find the time to include the individual's family and their needs. Families, lacking information and attention, may slowly detach from the situation, which could be counterproductive to building family resiliency. Leggatt (2002) summarized some of the differences between Western and Eastern societies views on mental health treatment and the role of the family, concluding that a partnership, in

which family is considered to be an equal part of the treatment team, yielded the best outcome for the individual.

According to Leggatt (2002), Eastern societies consider family to be an important part of the treatment process and do not place as much weight on confidentiality as Western society does. Most importantly, Leggatt (2002) acknowledged that family members and caregivers in developing countries play a critical role in the client's ressocialiszation, including training in vocational and social skills. This is partially due to the close family ties that have been in place in these developing countries for centuries; however, it can also be attributed to the lack of professional resources available in these parts of the world.

Pursuant to Leggatt's research, Wright (2007) studied the role that mental health professionals, as well as family members, play in an individual's treatment and concluded that the individual is best served when all parties work collaboratively. Wright described family-focused care as "a method of care delivery that recognizes and respects the pivotal role of the family (p. 15)." He predicted huge gains if mental health professionals could take a step back and treat and support the entire family (assuming the individual consents), as opposed to excluding the individual's main source of love and support. He reasoned that with more heads collectively strategizing and deciding on the best treatment options and supporting one another, the better off everyone will feel.

When a family pulls away, it is often difficult to determine whether the estrangement originated with the client, from an attempt to assert independence, or from the family, who slowly distanced themselves because they were tired of getting nowhere with their loved one or with the unwieldy mental health system. It is assumed that family members' intentions-at least initially- are to help their loved get well by supporting them on their journey through mental

health assessment, treatment, maintenance and relapse. Jamison (1999) suggests that when family members are more involved in the process of treatment, specifically when they are working with the providing doctors, outcomes seem to be more positive, for both the client and their family. Jamison (1999) also reported that when doctors, family members, friends and the individual work with one another, suicide is more likely to be prevented.

With that being said, certain laws in place make it exceptionally difficult for family members to play a supportive role in the care of a mentally ill individual. The Health Information Portability and Accountability Act (HIPAA) protects the individual's health information from being released without certain authorization to release information consent forms (Rouse, 2015). With limited access to information, resources, and treatment/discharge planning, family members are often left without answers or people to turn to with questions in times of need. According to research conducted by Dixon et al., (2001), when family members needs for "information, clinical guidance, and support are met," the treatment outcomes for the patient are likely to improve.

Dixon et al. (2001) also reviewed research that suggests a significant decrease in relapse rates and hospital readmissions among mentally ill individuals whose family members received psychoeducation. This specific study refers to psychoeducation as education provided to the individuals family regarding the illness itself, family support systems, problem solving techniques and crisis intervention work, including who to contact in a crisis and what constitutes a crisis.

Mental Illness and Crime

Hawthorne et al. (2012) summarize a report put out by the Treatment Advocacy Center which reports that there are 10 times more people suffering from mental illness in county jails

(149,000) and state prisons (207,000) than are receiving treatment in a state hospital (35,000). With the number of hospital beds shrinking, more mentally ill individuals are becoming homeless and resorting to crime. As an aside, is should be acknowledged that these statistics do not necessarily imply that mentally ill individuals are committing more crimes than before, instead, it reflects a lack of available treatment. Instead of being treated in the appropriate mental health forum, these individuals are labeled as criminals and are being sent to overcrowded jails, where they are being housed instead of rehabilitated.

According to Hawthorne et al. (2012), in 2007, there were over 2 million individuals that had been diagnosed with severe mental illness incarcerated in the United States. Supporting data from a special report issued by the United States Bureau of Just Statistics claimed that 64% of the inmates housed in jails had symptoms of mental illness. Hawthorne et al. (2012) assert that most of the research that has been reported regarding incarcerated mentally ill individuals has emerged from the correctional system's perspective. This is imperative to future research because, despite the statistics and information being released about incarcerated mentally ill individuals, not enough is known about the risk factors for these individuals being incarcerated. When it comes time to reintegrate these individuals back in to their community, they are failing, often resulting in reincarceration. Due to the alarmingly high number of incarcerated mentally ill individuals, both the criminal justice system, and the mental health system(s) have made it a priority to focus on reducing the criminalization of these individuals (Hawthorne et al., 2012). One way that this could be done is by improving the mental health treatment offered during and after incarceration.

Although jails do provide basic mental health treatment to inmates, the reduction of symptoms, development of effective coping skills and safety planning is not a priority for these

entities (Hawthorne et al., 2012). Instead, jails focus more on making sure that the individual is not a safety risk, to himself or other inmates. Corrections officers are not equipped with the education and skills necessary to facilitate effective mental health treatment. This is problematic considering the number of individuals who cycle through both the mental health and criminal justice system. Hawthorne et al. (2012) reported that individuals diagnosed with bipolar disorder or schizophrenia were more likely to be reincarcerated than those diagnosed with major depression. It was also found that individuals who received an adaptive service upon release from jail were less likely to be incarcerated again, as opposed to individuals that did not receive the service. Also, the individuals who received adaptive services upon release reported less adverse events, compared to individuals who did not receive the services (Hawthorne et al. 2012).

According to research presented by the American Psychological Association (Peterson, 2014), only 7.5% of crimes that had been committed by individuals with severe mental illness were considered to be directly related to symptoms of their illness. The concern with this number is that there is a disproportionately large number of individuals suffering from mental illness who are incarcerated every year, as well as serving probation or parole sentences, in the United States This is not necessarily due to the fact that these individuals are more dangerous. Although, when an individual with a serious mental illness commits a crime, especially a dangerous one, it tends to make national headlines.

Mental health professionals look at crime from a different perspective when it comes to individuals with mental illness. Because substance use is so prevalent amongst this population, and also because these individuals often experience symptoms beyond their control, research is proving that treatment is more effective than jail sentences. Jillian Peterson (2014) feels strongly

that programs for offenders with mental health problems should focus on issues of basic need

after incarceration in an effort to reduce recidivism. For example, these individuals should get

drug treatment, employment support and housing (Peterson, 2014).

Understanding how crime is correlated with mental illness is one small piece of a larger

puzzle. Marcowitz (2006), one researcher interested in the trends of homeless, mentally ill

individuals, published data covering 81 cities in the United States (2006). Marcowitz was

interested in the correlation of increased crime rates, and homelessness, and the dwindling

availability of inpatient psychiatric beds. Marcowitz reported that as the number of beds in our

state hospitals dwindled, the number of homeless individuals with mental illness rose, along with

the number of crimes and arrests being committed by this population (2006). Although this may

not seem surprising to professionals in the mental health or criminal field present day, this date

was contradicted by statistics released in the 1980's that suggested that within 6 months, around

30% of patients discharged from state hospitals had no identifiable residence (Drake et al.,

1989).

Amador (1999) presented data that suggests a correlation between a client living with

supportive family and a decrease in violence.

Hospital Readmission

According to research conducted by Heslin and Weiss (2015), there were almost 850,000

hospital admissions for reported mood disorders and over 380,000 admissions for reported

schizophrenia type illness in the United States in 2012. Within 30 days of discharge, 9% of those

patients hospitalized for mood disorders and 15.7% of individuals hospitalized for schizophrenia

were readmitted with the same principal diagnosis. Heslin and Weiss (2015) determined that

between the years of 2003 and 2011, inpatient psychiatric hospitalizations increased at a higher

rate than any other medical hospitalization-including, but not limited to medical , surgical, injury and maternal/neonatal. Specifically, Heslin and Weiss reported that among all hospitalizations in 2011, the 6th most common diagnosis was a mood disorder, which accounted for close to 900,000 hospitalizations (2015).

When individuals are readmitted to inpatient psychiatric hospitals, especially within a short period of time, it causes those on the outside looking in to wonder what went wrong along the treatment path for this individual. In reviewing the literature, it is clear that one should consider, and address, the fact that there is more than one perspective when evaluating causes for hospital readmission and potential improvements. For example, policymakers have been paying increased attention to readmission as it sheds light on possible missed opportunities to provide individuals with proper care, not to mention the fact that hospital readmissions are very costly.

There is a stigma surrounding readmission to a hospital as being a sign of defeat, indicating that treatment failed at some point (Jamison, 1999). If societal views could be swayed to accept that psychiatric hospitalization, including readmission, is a necessary treatment for serious problems, perhaps more individuals would seek voluntary treatment.

Policymakers only recently started to study and track some of the underlying causes for back-to-back hospital admissions and began to notice trends in the characteristics of those individuals receiving treatment. By tracking the trends in hospital admissions, policymakers aim to implement programs that are designed to improve the quality of the treatment delivered to these individuals.

Homelessness

The Treatment Advocacy Center (TAC) reports that, among the nearly 600,000 individuals who make up America's homeless population, one third of those individuals suffer

from an untreated major mental health disorder (2016). The American Psychological Association attributes many of the medical and mental health problems of homeless individuals to a lack of access to services (2016). Further research gathered from the National Coalition on Homelessness indicates that mental illness is a huge factor that contributes to an individual becoming homeless (2012).

Based on data linking mental illness and homelessness, many counties and agencies have chosen to implement programs geared toward the specific needs of this population. These types of programs are known as ACT programs, or Assertive Community Treatment. ACT programs are an alternative to standard case management programs that often don't address the specific needs of a homeless, mentally ill individual (NAMI, 2014).

Statistics on homeless mentally ill adults indicate that the population is increasing. Whether a person becomes homeless because they are mentally ill, or they are mentally ill due to years of homelessness is not the question at hand. What should be gained from this research is how to best reach out to this population and treat them in the most effective way in order to reduce psychiatric hospitalizations and improve their quality of life.

Psychiatric hospitalizations and homelessness have gone hand in hand in America. According to Markowitz, who studied psychiatric hospital bed availability, homelessness, and crime rates (specifically, number of arrests) across 81 cities in America, the decreasing number of inpatient psychiatric beds is correlated with an increase in homelessness among the mentally ill (2006).

Employment

Another factor that may contribute to re-hospitalization is unemployment among the mentally ill adult population. Despite what many people might think, individuals with mental

illness want to work and live an independent life. (NAMI, 2014) According to a report published by NAMI, entitled Road to Recovery: Employment and Mental Illness, individuals often refrain from disclosing mental illness to potential employers for fear that they won't be hired. Once hired, these individuals often then refrain from asking for workplace accommodations believing that the requests would have a negative effect on career advancement (2014).

Authors gathered data that demonstrate supported employment programs, when made available to individuals in need, and executed efficiently, can increase the number of adults with mental illness in the work force (NAMI, 2014). One of the most widely researched and effective programs supporting employment among the mentally ill is the Assertive Community Treatment (ACT) model. The ACT model consists of a multidisciplinary team that extends treatment to individuals in need throughout a community. What's different about this approach is that it is not a traditional office based outpatient program where all responsibility falls on the client. Within the ACT model, clients are offered medication management, substance abuse treatment, individual and group therapy, mobile crisis intervention, support with daily living tasks, linkage to community services, housing assistance, and employment services (NAMI, 2014).

What the authors of NAMI's report are arguing is that policies are not currently in place to support the needs of this population (2014). However, given adequate funding for supportive programs and less discrimination in the work force, adults with mental illness could be contributing and more independent and productive members of society. Perhaps this would help reduce their symptoms and need for inpatient psychiatric hospitalization.

Socio Economic Background

It seems that those who come from low-income communities tend to utilize outpatient treatment less often, and less effectively, than do those who are more financially secure.

According to Minuchin, Colapinto, and Minuchin (2007), poor families are often blamed for their problems and seen as a burden by societ. In addition to feeling judged, poor families view seeking treatment as being connected to government funded programs or agencies that want to assert control over the lives (Minuchin et al., 2007). These families often know their own deficiencies, however, are not willing to risk their children being taken away by professionals upholding minimum standards of care that the family may not be meeting. An interesting finding from Minuchin et al indicates that poor families often expect social service agencies to do something for them, such as find them housing or get them connected with services and help insurance); many poor families are unfamiliar with system and how to navigate, causing them to rely on other people (2007). In addition to this, Heslin and Weiss (2015) found that low income individuals, when admitted to a hospital for an initial stay with schizophrenia, were more likely to readmit to an inpatient setting with the same principal diagnosis (when compared to individuals who come from higher income communities).

Is the data in the literature skewed because research tends to gravitate to where the numbers are? In this case, is more known about readmission patterns in county hospitals versus upper class counties where people are more likely to pay out of pocket for private outpatient psychiatrists and therapists? Or, are the daily stressors that individuals from lower socio economic backgrounds suffer so detrimental to their overall functioning that their mental health is compromised and eventually they are unable to withstand the pressure of daily living? This dichotomy parallels that of the chicken and the egg; which came first. Despite valiant efforts to study the depths of mental illness, it's still not completely clear whether someone is mentally ill, and proceeds to make poor life choices, causing them to be out of work and homeless, or if

someone is born into a poor lifestyle with detached parents that causes their mental health issues to rise to the surface.

Stigma Surrounding Mental Health Treatment

It is difficult to imagine having to walk into a public mental health clinic to obtain services for a mental illness. It's even more unbearable to try to understand the thoughts that would be going through our minds if we were placed on an involuntary psychiatric hold at an inpatient hospital. This is a struggle that many Americans face on a daily basis however. In addition to the feelings of judgment they are forced to deal with simply upon entering the threshold of a mental health treatment center or psychiatric hospital, these individuals also have to face the internal struggles within their own minds as well as the often silent shunning from family and friends.

Although NAMI and other organizations nationwide fight the good fight to break down the stigmatic walls that surround mental illness, it feels as though it's not happening fast enough. Some individuals will never seek treatment because of the heavy burden of shame and embarrassment that society has put on the shoulders of those who might seek refuge from their symptoms. For these individuals, solace may come in the form of self-medication with drugs or alcohol, denial, or an even worse fate; suicide.

Medication Non-Compliance

Although it would be difficult to get an accurate percentage of individuals with mental illness who do not take their medication as prescribed, if at all, it goes without saying that medication non compliance is a big contributing factor to increased symptoms and likely hospital readmission. Having seen this first hand in many different treatment settings, whatever the reasons for medication non compliance, the outcome is consistent: increased substance use,

increased symptoms, decreased use of effective coping skills and the higher the risk of hospital admission and/or readmission.

Medication compliance within the mentally ill community is a good example of when an ACT program can help increase the likelihood of successful treatment. With the ability to follow their client's more closely by providing in home services, these intensive case management services provide a more support milieu for these individuals to thrive.

Substance Abuse

According to a foreword written by Peter Delaney in a report titled: Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health, "Each year, SAMHSA (Substance Abuse and Mental Health Services Administration) publishes the most recent annual results from the National Survey on Drug Use and Health (NSDUH) (2014)." This information is extremely important because the SAMHSA organization's primary task is to study trends on drug use among the mentally ill and use the data to reduce the impact that substance abuse and mental illness has across the counties in America. This national report, in particular, captures a comprehensive image of America's behavioral health for a moment in time (a year for example).

What is amazing to find in the literature is that Director's of major health care organizations, that are dedicated to studying substance use and mental illness, not only recognize that this country is seeing an incredible amount of change in the way healthcare should be and is being delivered, but also pledge to do something about it to meet the needs of the individuals that they serve. What is somewhat behind the literature, however, is the implementation of these ideas. It is known that health reform has been enacted and health care is being paid for differently, delivered to individuals differently and monitored differently than ever before.

Considering that close to 3.3 percent of all adults in 2014 had both 'any mental illness' and a substance use disorder in the past year, and even more alarming, 1 percent had both a serious mental illness in addition to a substance use disorder (National Alliance on Mental Illness, 2014), it is surprising that mental illness and substance use disorder aren't treated together as often as they could be. A study published in the Journal of the American Medical Association (JAMA) indicated that 44% of individuals who reported abusing alcohol (and 64.4% of 'other' substance abusers) had at least one serious mental illness (Regier er al., 1990). It seems important to mention that clinicians will be required to differentiate between actual mental illness and drug-induced symptoms.

For example, some individuals use drugs and alcohol to cope with preexisting mental health problems, where as others developed mental illness as a result of drug use. Certain substances are linked with an increased risk of developing mental health problems (Inaba, Cohen 2004). In support of this statement, Kessler et al., (1994) reported that 75% of individuals who abused cocaine also had a mental health disorder. The same was true tor those who reported smoking marijuana daily. Looking at things from the other side of the fence, research still indicates a high correlation of individuals with mental illness who begin using drugs. Overall, around 30% of mentally ill individuals had a problem with substance abuse (Regier et al., 1990).

Knowing the statistics of the correlation between mental illness and substance abuse is of no use to the field of psychology unless it can be translated into meaning information that will aid in the development of treatment programs to reduce the correlation. Watkins et al. (2001) found that of the 7-13 millions individuals suffer from both a mental illness and substance abuse, 23% of them received treatment for their mental illness only. In addition to this, they found that 9% of the dually diagnosed individuals received only substance abuse treatment. This leaves

only 8% of these individuals who received both mental health and substance abuse treatment together.

Inadequate Outpatient Treatment Options

When an individual is discharged from an inpatient psychiatric hospital, oftentimes they are left to their own devices in terms of following up with outpatient treatment. However, just because a client no longer meets acuity standards to be held at an inpatient setting does not meet that they are capable, or willing, to make the necessary arrangements for outpatient mental health treatment.

Even if there were a plethora of facilities dedicated to providing outpatient mental health treatment, these individuals, who have just been released from an acute setting, would be responsible for finding a program that takes their insurance (or one they can afford), work it out with their schedule (if they are fortunate enough to have a job), and arrange for transportation to and from the appointments (to the clinic as well as any lab or pharmacy if blood tests are needed or prescriptions are written). It is almost as if the system sets vulnerable individuals up to fail at their weakest point when they need the most support.

One proposal that has been implemented in some counties to reduce the number of hospital readmissions and ensure that patients follow up with outpatient treatment is involuntary outpatient commitment (IOC). The idea behind IOC, according to Elbogen and Tomkins (2000), is to make the transition from the inpatient setting back to the community safer, more therapeutic and more likely to reinforce positive thoughts regarding treatment.

Within IOC programs, the stated goal of treatment is often to reduce readmission to the psychiatric hospital (Draine, 1997). However, Draine reported that studies of these intensive programs can actually have the opposite effect. According to Draine (2000), with an IOC

program design comes increased supervision from mental health professionals. From the clients'

perspective, this can be seen as a loss of control, as they are given limited choices and made to

believe that if they do not comply that they will be readmitted to the hospital (Draine, 1997). If

coercion from the mental health professionals in the IOC program is not bad enough for the

clients, the increased supervision from these professionals increases the likelihood that other

systems that the client may be involved with are watching closely as well, for example the

criminal justice system if involved in probation cases or child welfare investigations (Draine,

1997).

Although the research on IOC programs seems divided, some researchers would argue

that there is no overwhelming evidence to suggest that IOC programs are correlated with

significant benefits or harm (Hotopf et al., 2007). However, IOC programs have been in place

since the 1980s in most states and continue to be utilized today. According to the Treatment

Advocacy Center (Assisted Outpatient, 2016), there is a plethora of research that indicates that

IOC programs reduce the risk of hospitalization, arrest, incarceration and violence. In addition to

the benefits it appears to reap for the individuals, research also suggests that IOC programs

reduce the strain that is weighing down families care for a mentally ill loved one (Assisted

Outpatient, 2016).

Perhaps one of the reasons that IOC programs are criticized stems from the inconsistency

of treatment delivery (Elbogen & Tomkins, 2000). Without clears guidelines defining the

implementation of treatment within IOC programs, there is a lack of accountability, on both the

client receiving the services and the professionals delivering the treatment. Other reasons that

IOC programs may be avoided include the lack of buy in from some mental professionals, cost

of providing treatment in this setting and lack of resources. It can be argued that when treatment

has to be forced upon an individual, its effectiveness may be reduced dramatically (Elbogen &
Tomkins, 2000).

One example of a tightly-controlled outpatient program exists in Ventura County, CA.
According to 'Assist', Ventura County's Assisted Outpatient Treatment Program (2017), there
are certain requirements regarding who can refer an individual to the program and strict criteria
that must be met before the case is presented to a judge. This program, which came to life after
the initiation of "Laura's Law," was intended for adults who suffer from a serious and persistent
mental illness, however, have been resistant to seeking or accepting treatment that is offered to
them. As stated on a summary sheet published by Ventura County Behavioral Health, and the
organization contracted to provide the treatment, Telecare Corporation, the program employs a
client centered approach when it comes to outreaching and engaging with the referred individual
in the hope that they will voluntarily accept services. If the first approach fails, the option
remains to pursue court ordered treatment, when severe circumstances exist.

Laura's Law is outlined by specific criteria that county supervisors demand be met prior
to admission into the program (Treatment Advocacy Center). The criteria for acceptance into this
"court ordered treatment" clearly state that the individual meet the following outlined criteria:
have a condition likely to substantially deteriorate, be unlikely to survive safely in community
without supervision, have a history of noncompliance that includes two hospitalizations in the
past 36 months, or act/threaten/attempt of violence to self/others in 48 months immediately
preceding petition filing, be likely to need treatment to prevent meeting inpatient standard, and
be likely to benefit from assisted treatment.

Laura's Law, although it may appear to some as a quick fix, is in fact surrounded by controversy. The name came from a tragic story that made headlines nearly 16 years ago when a man who suffered from mental health problems murdered a 19-year-old woman, Laura Wilcox. Laura was working at a mental health clinic in Nevada when she was killed (Childers, 2016).

It was Laura's parents who fought for legislation changes that they felt would prevent similar catastrophes from happening in the future. Adoption of Laura's Law has been slow as it has faced resistance from consumers, legal organizations and certain advocates claiming that the treatment does not work. However, most family members and professionals in the field consider Laura's Law as a bridge to recovery, "a way to stop the revolving door of repeated hospitalizations, homelessness and jailing's (Childers, 2016)."

Personal Experience

The frequency of clients readmitting to psychiatric hospitals was something that caught my attention within the first 30 days as a doctoral intern on an acute inpatient psychiatric unit. I was placed in the case management department, tasked with discharge planning. This involved coordinating rides off the hospital campus, arranging for outpatient treatment, and ensuring that the client had a place to live. I soon began to notice familiar faces returning to my caseload. Immediately, I started to question whether I had failed the client in obtaining appropriate resources once they left the structured and secure setting of the hospital. While it is impossible to know if every program was a perfect fit for every client that I linked together, what I can say is that it would be a short and defeating career to assume that I held all of the power to navigate an individual's course of treatment entirely on my own. So, I began to wonder what else could be contributing to these individuals' almost cyclical patterns of return to the not so humble setting that I often dreaded walking into myself each morning.

I began to do a little more research with every client that I had the opportunity to meet with on more than one occasion. Not so much to my surprise, as to my relief, it was becoming clearer to me that there were, in fact, many factors contributing to these individuals' readmission to the hospital. For some, it was a conscious effort; a decision that they knowingly made on their own. The reasons for voluntary readmission varied; however, they include a desire for further treatment and prevention of symptoms, the need for a warm place to stay for 72 hours with meals provided, a longing for the attention provided by the staff to individuals who might have otherwise been lonely, and unfamiliarity with, and an inability to access, mental health services on their own. Contrary to the argument I make above, some individuals even expressed that being in the hospital was an escape for them; not only physical space from loved ones, but also a mental break that was needed in order for them to recover.

For others, the hospital readmission was an involuntary process that came with a fight, along with a begrudging attitude. Because it was an acute unit, many clients were detained on an involuntary basis and did not have a say in the matter. These individuals often presented with acute symptoms, such as psychosis, suicidal or homicidal ideation, or had decompensated so severely that they were unable to care for themselves on the most basic human level. It would not be long before a concerned citizen, loved one, law enforcement officer or mental health professional came into contact with said individual who was struggling mentally; someone inevitably felt forced to intervene. It was often with these clients, however, that treatment was most difficult to enforce. These individuals were often indigent, of low socio economic status, dually diagnosed, lacking in family support, and unwilling to follow up with medication compliance or an outpatient program.

Without a solid plan for outpatient treatment and a good support system in place to help nurture the ongoing treatment that is often required for these individuals to maintain stability, they soon revert to old behaviors. This is the revolving door that haunts the families and individuals who suffer from severe mental illness. It often leads families and mental health professionals alike to wonder: how much of this problem is attributed to a broken mental health system versus an individual's free will?

I do not believe that the mental health system is broken. Unlike certain medical conditions that may not have a cure, mental illnesses are real problems and have real treatments. The problem lies in the fact that far too many people are not accessing appropriate treatment, for whatever reason. What motivates an individual with mental illness to choose recovery? What motivates them to maintain negative and unhealthy lifestyle choices?

Many adults on the unit had expressed a strong desire to be in charge of their own life; to not be told what to do and when to do it. By not attending outpatient mental health treatment because a psychiatrist whom they've met for a total of 15 minutes suggested it would be helpful, they feel validated and in charge of their lives. Clients have also expressed a desire to avoid the stigma that surrounds mental health treatment. This includes walking into a mental health treatment center as well as taking medication. For others, it is denial that they have a problem at all. Denial, which more than likely stems from an accumulation of symptoms, causes a lack of insight into the severity of their problems. If the individual truly does not feel that a problem exists, they are not likely to seek treatment or a solution.

After spending an entire year on the acute unit, many client's come to mind as I ponder the many variables involved in hospital readmission. I recall clients who were readmitted not only once or twice, but three, four and even five times during my year of learning. With that

being said, I'm also pleasantly reminded of client's whom I never saw again once they left the security of the hospital. It is with great faith in this field that I believe that these individuals did not return because once their treatment goals were met in the hospital, they followed up with their suggested outpatient treatment and/or their outside support system was enough to get them through the tough times of life.

I have many heartbreaking stories that have yet to see a happy ending. Clients who don't believe in themselves enough to try, providers who are burnt out on treating the same person without any progress, and families who are sick and tired of being sick and tired. These are the chronically homeless people who wander the streets of our country talking to themselves, sleeping in parks, using drugs instead of taking medication and refusing help being offered to them because their experience-thus far hasn't proven useful. Burn out is common in the mental health field. The profession often requires long hours, patience, and work outside of daily required duties, with little given in return other than the hope that someone's life is a tiny bit better because of support, knowledge, or resources given to them.

With that being said, it must be known that for every tragic story that I can recall, my heart is warmed with the feelings of joy and gratitude that I have for two clients and their families that allowed me to come into their life and be a part of their journey to healing. What I have come to learn in my own journey is that healing comes in many forms. It does not mean that someone is healed only once they leave a hospital, never to readmitted. It can mean a reduction of readmissions from 10 times a year to three. Healing can be a family reunification. Healing can be an individual choosing to say no to drugs and yes to a partial hospitalization program for the first time. Healing can be a depressed individual choosing to get out of bed and

live their life one more day. Healing is defined by the individual who requires it, not by the

facilitator tasked with aiding in the process.

Chapter III Research Design and Methodology

Description of Research Design

Data for this study of family estrangement and hospital readmission rates was obtained from a southern California county outpatient mental health system electronic database. In order to further protect the confidential patient information, the name of the county, or the database, will not be disclosed. This archival data will be gathered directly from said electronic database; no individual persons were interviewed.

The charts in which data will be used for analysis were chosen based on whether or not the individual was psychiatrically hospitalized in an inpatient setting in the year 2014. From the generated list of individuals hospitalized in the year 2014, the first 60 individuals, who have an assigned identification number to further protect their identity, were utilized in this study. Although the individuals' names were visible to the researcher while in the electronic database, their 5-6 number identification code was the only link to their information, while data is being analyzed. The researcher only had access to the charts for the amount of time required to complete the study and under the supervision of the county's clinical research team. Charts were reviewed in a secure room within a county mental health building, using a county desktop computer, and accessible only by county mental health staff. The data collected from the charts was typed onto a spreadsheet; no copies made and no entry into an electronic system occurred until the information was entered into the SPSS software.

Many variables were utilized in the data analysis, including: whether or not the individual lives with a family or friend, whether or not there is an emergency contact listed in their electronic record, whether or not they have a job and meaningful relationships with coworkers (as evidenced by documentation in psychiatric notes), the number of psychiatric hospital

admissions, the number of years of outpatient treatment, the number of contacts with the hospitals assessment and referral department, and the number of contacts each individual had with the Crisis Team.

For the sake of this discussion, family estrangement was noted when no emergency contact was listed and the individual lived alone. If there was an emergency contact listed and the individual lived with friends or family, it was assumed that they have positive social support.

Procedures

No individuals were involved in this study. In fact, any researcher wishing to duplicate this research would only need access to county outpatient mental health records. From these individual records, the researcher would gather information relevant to the study, including, but not necessarily limited to, history of psychiatric hospitalization, history of drug use or legal issues, current living situation and history of outpatient treatment. If information is missing from the individuals' file, or is too vague to interpret without error, that should be noted. In the current study, identifying patient information has been redacted. If this was not possible in a future study designed to duplicate these findings, researchers would want to give anonymous codes to each individual whose information was logged, so as not to breach confidentiality.

In an effort to establish inter-rater reliability, this researcher created a questionnaire to help determine what factors are considered to be strong indicators of positive social support. The questionnaire was dispersed to 9 professionals in the mental health field, including licensed and associate marriage and family therapists, a licensed social worker, registered nurse, and licensed psychiatric technicians. The participants were asked to rank 7 variables using a 5-point Likert scale (with 1 being not important and 5 being very important). All of the 9 participates reported feeling that 'living with a friend or family member' demonstrated positive social support (ranked

3 or higher), as opposed to family estrangement. Also, the 9 participants felt strongly that listing an emergency contact showed family involvement, an indicator of positive social support.

Participants

Participants were a convenience sample of 64 individuals who were admitted to an inpatient psychiatric hospital in the year 2014. The main criterion for inclusion is that the individual was assessed for immediate risk and that it was determined that psychiatric hospital admission was the necessary course of treatment. Whether the individual was admitted on a voluntary or involuntary status will not be tracked for this study. Study subjects were adults, aged 18 years and older; adolescent patients will not be included in this study.

Data Entry and Analysis

Historical data collected from the above mentioned county outpatient mental health electronic database was analyzed, scored, coded, and then entered into a descriptive SPSS data sheet. All information pertaining to participants' identities were previously redacted. This study was conducted as a one-tailed t test and will utilize a correlation coefficient to determine the relationship between the independent variable of estrangement and dependent variable of readmission. The probability was set at less than 5% (p<.05) in order to show that the relationship between the two variables is not due to chance alone.

Once the data was collected, it was analyzed and interpreted. What will be analyzed first and foremost is the correlation, if any, between family estrangement and psychiatric hospital readmissions.

Data was interpreted using the computer statistic software program, SPSS. This is a process in which the raw data collected from the admission paperwork was entered into the computer program and transformed into measurable and understandable information that was

used to determine what variables, if any, correlated to increased hospital readmissions. Conversely, variables were explored that are inversely correlated to hospital readmissions. These may serve as protective factors, helping to keep individuals out of hospital settings as their symptoms are managed on an outpatient basis or in the community.

Chapter IV Results

Bivariate Distributions

Examining scatterplots of the bivariate relationships between the number of years out outpatient treatment and each of the outcome variables demonstrated that all three of these bivariate relationships were all non-linear. In order to create linear bivariate between these variables, it was decided that each outcome variable, and the number of years of outpatient treatment, would be transformed utilizing the natural logarithm. After transformation, the bivariate relationship between the transformed version of years of outpatient treatment and each of the three transformed outcome variables then resembled a linear relationship.

Model Building 1: Number of Inpatient Psychiatric Hospital Admissions

Of all of the predictors in this analysis, the only variable related to the number of inpatient psychiatric hospital admissions (log transformed) was the years of outpatient treatment (log transformed). The relationship between the number of inpatient psychiatric hospital admissions (log transformed) and the years of outpatient treatment (log transformed) was significant (p<.001) and the slope coefficient for the model was 1:1. This means, that if the number of years of outpatient treatment increases by 1%, the number of inpatient psychiatric hospital admissions increase by 1.1%.

Model Building 2: Number of Crisis Team Contacts

Similarly, for the number of Crisis Team contacts, of all of the predictors in this analysis, the only variable related to the number of Crisis Team contacts (log transformed) was the number of years of outpatient treatment (log transformed). The relationship was significant (p<.001) and the slope coefficient for the model was 1.34. Thus, for the number of Crisis Team

contacts, there was a slightly bigger increase. For every 1% increase in the number of years of outpatient treatment, there was an increase of 1.34% in the number of Crisis Team contacts.

Model Building 3: Number of Admissions to the Assessment and Referral Department

Finally, the number of contacts with the assessment and referral department (log transformed) was also significantly related to the number of years of outpatient treatment (log transformed) ($p<.001$). In addition, however, it was significantly related to whether or not the participant lived with a family or friend ($p<.05$).

The results indicated that controlling for whether or not the individual lived with a family or friend, for every additional 1% increase in the number of years of outpatient treatment, admissions to the assessment and referral department increased by 1.44%. When controlling for the number of years of outpatient treatment, living with a friend or family member decreased the number of admissions to the assessment and referral department by .64% ($p<.05$). This demonstrated the only significant negative relationship.

Chapter V Discussion

Unfortunately, the results did not necessarily prove that family estrangement is linked with an increase in psychiatric hospitalization, as was suggested by previous research by Jamison (1999), who highlighted how risk factors such as lack of support and involvement from friends and family increases symptoms and suicide attempts among mentally ill individuals. It is unclear as to why there is no significant correlation between the number of inpatient psychiatric hospitalizations and the number of Crisis Team contacts. However, when looking at the number of admissions to the assessment and referral department, positive social support is a protective factor. If a participant lived with a friend or family member, this was associated with a decrease in the number of admissions that they had to the assessment and referral department.

The fact that data analysis demonstrated that when an individual lives with friends or family members, their number of admissions to the assessment and referral department decreased by 1.34% supports the theory behind this research, as well as previous research in the field. As Ossman & Mahmoud (2012) reported, individuals with mental health problems are typically more socially isolated, compared to the general population. Because of the social isolation that these individuals endure, they are prone to many poor outcomes, such as decreased self-esteem, increased symptoms and more frequent, and longer lasting, inpatient psychiatric hospital stays (Ossman & Mahmoud, 2012).

One thing that stood out as surprising when analyzing this data was the fact that the more years an individual spent in outpatient treatment, the more admissions they had to inpatient psychiatric hospitals. It was assumed at the start of this research that adherence to outpatient mental health treatment would be correlated with decreased inpatient psychiatric hospital readmission rates. Similarly, Heslin et al. reported (2015) reported that continuity of effective

outpatient services was linked to a decrease in the probability that an individual would be readmitted to an inpatient psychiatric hospital setting.

Methodological Assumptions and Limitations

Within this study, some of the noted limitations include, but are certainly not limited to, the fact that the data originates from only one county's outpatient mental health program. Because only information from said county can be viewed in the electronic database, if an individual received outpatient treatment, or was psychiatrically hospitalized in an inpatient setting, in another county, that information will not be accessible. Also, time is a limitation. The data set was gathered solely from records of individuals who were hospitalized in a specific year, excluding other individuals who may have a long history of psychiatric hospitalization, however, were not flagged as they were not hospitalized in 2014. Another time limitation is the electronic database itself. The database only includes information dating back to the year 2000. Thus, if an individual had any inpatient psychiatric hospitalizations or received outpatient treatment prior to the year 2000, it will not be accessible.

Another limitation is that the term 'family estrangement' is based on indicators of positive social support, as determined by 9 professionals in the mental health field. Taking the limitation a step further, this researcher was only able to utilize information regarding these indicators of positive social support based on the available information, as opposed to speaking directly with the individual. Because individual participation was not utilized, clarification questions were a luxury not afforded in this study. Also, although the information analyzed was gathered from an electronic database, the researcher was not involved in obtaining the original information from the individual. It is assumed that the information gathered within this database is accurate and was obtained by a reliable clinician. It is worth noting that data collection reflects

the accuracy and judgment of the hospital admission staff members working only during that time. With that being said, some of records are not complete, meaning that some information regarding outpatient treatment and the number of inpatient psychiatric hospital admissions was missing.

This study will have limited ethical concerns with regards to the individuals whose demographic information will be utilized. This is due to the fact that the data collected for the purpose of this study was archival, and did not require any interaction or actual participation from those individuals whose information was utilized.

Implications for Further Research

Utilizing the data gathered and analyzed for the purpose of this study, it is the hope that further research on the subject of family estrangement and inpatient psychiatric hospitalization is jump-started. One main concept suggested to explore further is the collective family unit's interpretation of estrangement. For example, what it means, how it occurs, and if it's repairable. If family estrangement was better understood, programs involving an individuals support network could be implemented at critical times in their recovery, hopefully reducing the number of inpatient psychiatric hospital admissions. It would also be helpful to be able to understand why families feel they stay together, why they feel they were unable to maintain connectedness, where they think things went wrong, and, most importantly, what could have been done to help them remain connected. Program development regarding the inclusion of a social support system should be instrumental in aiding the recovery of individuals with mental illness.

Also, in terms of researching the topic of inpatient psychiatric hospital admissions even further, it should not be assumed that the only variable of importance is that of family estrangement. In fact, quite the opposite should be assumed. Perhaps this study will lead to

further research and reveal other important correlations that influence hospital readmission rates (although others may exist, it will be beyond the scope of this current research). For example, in regards to inpatient psychiatric hospital admissions, readmission rates may be influenced by co-occurring disorders that are not being diagnosed or treated properly, such as drug abuse or medical conditions.

It also seems important to further study the role that outpatient treatment has on the number of times an individual is readmitted to an inpatient psychiatric hospital. Exploring, in more depth, what components of effective outpatient treatment in the community are associated with decreased inpatient psychiatric hospital readmission rates would be beneficial not only to the individuals receiving the treatment, but also to the community as a whole (in terms of financial strain and future program development).

In conclusion, it is assumed that many factors are associated with how often an individual is readmitted to an inpatient psychiatric hospital. Determining how these variables affect individuals with mental illness will be the task moving forward. Each individual has unique needs and is impacted by many variables in the world around them. Programs designed to include friends and family in the treatment of an individuals mental illness, and that foster a place rich in support for these individuals, would likely benefit all involved.

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