State Hospital Rotations Allow Residents to Regain the Longitudinal Experiences of Yesteryear

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> Exposing residents only to brief inpatient stays, without the opportunity to subsequently follow the patient, runs the risk of legitimizing fragmented care and prevents the resident from understanding the full impact of their treatment or the natural evolution of the patient's illness. Roy Houghtalen and Laurence Guttmacher, 1996 (Ref. 1, p 117–8)

Over the past 60 years, the length of inpatient psychiatric hospitalizations has dramatically decreased, now ranging days to weeks rather than months to years.[2–5] The national average length of stay for adults in short-term psychiatric hospitals is approximately one week.[4,6–8] After discharge from an inpatient unit, there is a high rate of nonadherence with treatment recommendations, both postdischarge appointments[9,10] and medications.[11] Besides the significant impact this has on patient care, it is particularly problematic from an educational perspective. It limits the opportunity for trainees to see the natural evolution of severe mental illness and potential treatment response.

Given the need for psychiatrists to assess the nature and cause of a patient's described symptoms and guide treatment, the influence of our current mental health system on trainees' clinical proficiency merits further research. Notably, the length of stay in state hospitals remains high.[4,12] They are also increasingly populated with forensic cases.[13,14] The ethics implications of this disparity are beyond the scope of this article. This editorial instead strives to highlight the associated educational opportunity and recommend that program directors and forensic psychiatrists alike consider state hospital systems as a vital part of residency training, not just for exposure to forensic psychiatry[15] but to mitigate the educational impact of our nation's current scheme of brief inpatient hospitalizations.

Varying Perspectives on High Utilizers

I vividly remember one of my first external moonlighting shifts as a resident at a local psychiatric emergency room. Shortly after my shift started, a purported "frequent flier" was brought into triage by police. The charge nurse, who had been at the hospital for many years, pulled me aside. She told me that it was important I quickly discharge the patient. He was known to be violent if admitted, and there was no need to admit him; he had not benefited from his numerous past hospitalizations. I do not remember the interview that followed. I do remember doing what I was advised and quickly discharging the patient.

The pejorative phrase "frequent flier" is used to describe high health care utilizers, particularly in emergency rooms.[16] These patients have higher rates of severe mental illness and often behavioral outbursts leading to an emergent psychiatric evaluation[17] or incarceration.[18] Although data on this topic are limited,[19] this population appears to have higher rates of comorbid substance use and personality disorders.[17] They prompt strong feelings from staff and clinicians alike, in part because of a lack of available resources in the community and an associated feeling of helplessness by those providing care in emergency settings.[20] This population often ends up in the state

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hospital system, a resource that is decreasing in availability.[14]

In my current role as a forensic psychiatrist leading a competency evaluation and restoration unit at a state hospital, I routinely evaluate and treat these individuals. Although my sample is skewed, I regularly find that, prior to their arrest, my patients had repeated (rapid) discharges from emergency rooms and inpatient psychiatric units. Despite the psychosis that I observe them displaying in the controlled hospital setting, their previous discharges were frequently predicated on purported malingering, substance-induced psychosis, or antisocial personality disorder. With lengthy inpatient treatment, ranging from weeks to months, most of these individuals do in fact improve, both clinically and for competence restoration purposes.

When I lecture to police officers at their crisis intervention training (CIT), they share their side of the story and emotional response to their own experiences with such individuals. They often describe the anger and frustration they feel dropping off agitated and seemingly ill individuals for help in an emergency department, only to find them walking down the street several hours later without any meaningful interventions to mitigate risk. Many officers have implied that it is these types of experiences that make them less willing to take detainees with mental illness into diversionary facilities, and less trusting of the mental health system as a whole.

Our Unique View as Forensic Psychiatrists

As forensic psychiatrists, we have a unique perspective on the impact of system effects on patients with severe and persistent mental illness. Our perspective arises in part from our ability to obtain and review extensive records detailing a patient's life story and health care experiences. But more pertinently for purposes of this editorial, our perspective comes from the opportunity to longitudinally treat these patients in controlled settings similar to what our predecessors had in the 1970s. We are able to watch how, with consistent and adequate care, this population can transition from profound disorganization to coherence.

I echo the sentiments of those before me that residencies should place more weight on forensic rotations.[21–23] I add the recommendation that these rotations should provide the ability to follow forensic inpatients for extended periods of time. This is vital, as it gives residents what they have otherwise mostly lost: the ability to watch the natural course of severe mental illness when it is sufficiently treated on a long-term basis.

Forensic "Experiences" in Residency

General psychiatry residency programs are required by the Accreditation Council for Graduate Medical Education (ACGME) to provide a forensic "experience."[24] The American Academy of Psychiatry and the Law's (AAPL's) Practice Resource for Forensic Training in General Psychiatry Residency Programs[15] provides a detailed list of all of the reasons that this is an important part of training: teaching basic forensic skills inherent in the practice of psychiatry (such as informed consent), providing an understanding of the legal regulation of psychiatry, fostering an interest in forensic psychiatry, and offering an environment where trainees can treat "justice-involved patients."

Although there are programs with mandatory forensic rotations,[25,26] it is not required by the ACGME. Furthermore, residency programs often have limited access to the forensic experiences provided in fellowship, either because of geographic location, lack of forensic faculty, financial constraints, or limited training time.[15,27] As a result, residents' formal forensic experience more often entails classroom instruction and academic exercises.[15,26]

A Longitudinal Forensic Experience

I am fortunate to be in a geographic area rich with forensic faculty and experiences for interested residents. Local medical students and residents frequently join our forensic fellows at the state hospital, participating in a month-long forensic experience. In this editorial, I want to highlight a more recent educational offering.

For the past year, thanks to the assistance of Cathleen Cerny-Suelzer, MD, our fourth-year psychiatry residents have had the option of partaking in the pilot program of a "longitudinal forensic" rotation. We had not, at the outset, expected the nature and magnitude of the educational benefits residents would gain from this experience or how different the training they received would be compared with that on a typical inpatient unit. It has, however, been quite impressive.

The longitudinal forensic rotation is one half-day a week for six months on a competence restoration unit at Northcoast Behavioral Health Care (a state

hospital in Ohio). In Ohio, defendants with higher level felonies can receive up to a year of inpatient competence restoration treatment.[28] If they are adjudicated unrestorable on such a charge, they face the prospect of remaining hospitalized for up to the maximum sentence they would have received if found guilty of their alleged crimes.[29]

During the pilot of this longitudinal forensic rotation, residents have been assigned four to five competence restoration patients. I choose patients who had initially been admitted for an inpatient competence evaluation (as they tend to have more historical treatment data available) and then recently adjudicated incompetent to stand trial, restorable. I prioritize assigning patients who are not actively aggressive, are prone to be hospitalized for at least six months of competence restoration treatment, have prominent positive symptoms, and are clozapine candidates. The residents take primary care of their patients; I follow along separately and guide treatment.

My stated goals for resident education are that they appreciate the heterogeneity of psychotic disorders and the potential trajectories of improvement, recognize the system failures and misdiagnoses that often preceded their patient's arrest, and find and empathize with their patient's "goodness" and humanity, mentally putting aside their criminal charge.

The Impact of Varying Lengths of Stay

Over the past 60 years, length of hospital stays has drastically reduced.[30,31] This reduction has been seen in both medical and psychiatric hospitalizations but more profoundly with the psychiatric ones. This is a result of many factors, including, but not limited to, fewer psychiatric beds (as a result of the deinstitutionalization movement), increased emphasis on community-based care, and financial constraints secondary to managed care.[32] As a result, whereas a community psychiatric hospitalization in the 1970s and 1980s routinely lasted 30 to 90 days, the expectation in today's era is for the same hospitalization to last five to ten days.[3]

In 1996, Rory Houghtalen and Laurence Guttmacher wrote an article about this trend, pointing out the various ways it could affect resident education.[1] They compared three second-year resident caseloads on a general adult inpatient unit. The residents' patients during the 1979–1980 academic year had a mean length of stay of 29 days. During the 1994–1995 academic year, it was 12 days. Houghtalen and Guttmacher pointed out that modern (civil) psychiatric units were increasingly focusing on "ameliorating risk" and "barely resemble[d] the inpatient unit of yesteryear" (Ref. 1, p 112). They noted the lack of opportunity for prolonged inpatient psychotherapy, the faster pace of treatment, and a census that necessarily included "sicker and more complicated" patients (Ref. 1, p 116).

Given the several-week treatment course recommended when assessing a clinical response,[33,34] modern psychiatrists train in an informational vacuum. Residents working on civil psychiatric units do not get an opportunity to watch the natural trajectory of a treatment response in severe mental illness. Although they can follow their patients on an outpatient basis after discharge, the educational value of that experience is impaired by high rates of nonadherence[35] and comorbid substance use disorders[36] (which can, in turn, worsen medication nonadherence while independently producing or increasing psychiatric symptoms).

Treatment guidelines recommend that patients remain adherent with therapeutic doses of an antipsychotic medication for several weeks before deciding if it is effective. From a symptom perspective, patients treated with an antipsychotic medication reportedly show clinical response for hallucinations after a median time of 27 days and delusions 76 days (with a mean of 59 and 150 days, respectively).[37] Inpatient civil hospitalizations number in days. Residents are thus expected to treat symptoms, and disorders, with limited opportunity to ever watch the progression of improvement.

Although the length of state hospitalizations has decreased over the past few decades, they have remained long.[12] They are often more akin to the civil hospitalizations of the past. Such a setting provides an educational opportunity. Residents can observe the natural trajectory of psychiatric improvement over weeks to months of treatment. Furthermore, their patients are in controlled settings with reduced access to illicit substances and increased monitoring of medication adherence.

Final Thoughts

When I assign a treatment case to trainees, I suggest that they review the patient's voluminous records and make note of how our fragmented and inadequate mental health system and criminalization of mental illness have led their patients to where they

are today. I want them to see the patient's victimization rather than just the alleged criminality. Thus far, I believe this has succeeded. Each resident who has finished the longitudinal rotation has talked about patients with fondness and hopefulness that the judge will ultimately see the patients for who they are rather than just what they allegedly did.

Longitudinal rotations in state hospitals offer unique and valuable training opportunities for residents. In addition to humanizing forensic populations, such a rotation lets residents regain a necessary experience: observing the natural evolution of severe and persistent mental illness while providing treatment aimed at clinical stability rather than rapid discharge into a fragmented ambulatory system.

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