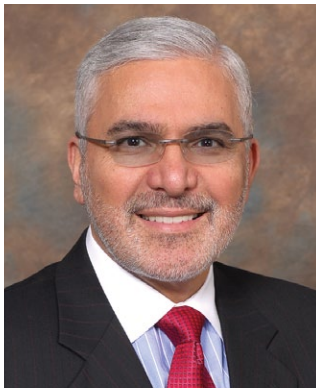

Henry A. Nasrallah, MD
Editor-in-Chief

Needed: A biopsychosocial 'therapeutic placenta' for people with schizophrenia

Schizophrenia and stroke are 2 serious brain disorders that involve brain damage and disability. Yet the difference between the 2 disorders is stunning in terms of how resources are invested for their acute treatment and long-term rehabilitation.

I propose the term 'therapeutic placenta' to describe what people with disabling severe mental illness deserve—what stroke patients already receive

Consider stroke. Guidelines for acute treatment, access, intervention, prevention of post-hospitalization relapse, and rehabilitation are extensively spelled out and implemented.[1] (See this article on CurrentPsychiatry.com for a ***Box*** that outlines Mayo Clinic guidelines for stroke management, as a demonstration of the comprehensiveness of the approach.)

Schizophrenia and related severe mental illnesses (SMI) need a similar all-inclusive system that seamlessly provides the myriad components of care needed for this vulnerable population. I propose the term "therapeutic placenta" to describe what people with a disabling SMI brain disorder deserve, just as stroke patients do.

Closing asylums: Psychosocial *abruptio placentae*

In a past Editorial,[2] I described the appalling consequences of eliminating the asylum, an entity that I believe must be a key component of the SMI therapeutic placenta. The asylum is to schizophrenia as the skilled nursing home is to stroke. SMI patients suffered extensively when asylums were shut down; they lost a medical refuge with psychiatric and primary care, nursing and social work support, occupational and recreational therapies, and work therapy (farming, carpentry shop, cafeteria, laundry, etc.). For SMI, these services are the psychosocial counterpart of various physical rehabilitation therapies for stroke patients that no one would ever dare to eliminate.

Persons with schizophrenia and other SMI have suffered tragically with rupture of the main components of the therapeutic placenta that existed for decades before the advent of medications. The massive homelessness, widespread incarceration, persistent poverty, rampant access to alcohol and drugs of abuse, early death due to lack of primary care, and absence of meaningful opportunities for vocational rehabilitation are all consequences of a neglectful society that refuses to fund a therapeutic placenta for the SMI population.

The public mental health system in charge of SMI patients is broken, disconnected, and failing to pro-

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Table

For people with severe mental illness, proposed components of a therapeutic placenta

• Genetic counseling for families in whom mental illness is present
• Excellent prenatal care for all pregnant women, regardless of family history, because brain insults in pregnancy predispose to SMI in offspring
• Physical and mental pediatric care, with referral to child psychiatry as needed
• Early identification of at-risk persons
• Quick access to, and full insurance coverage of, outpatient mental health services
• Rapid hospitalization when the acute episode emerges and a comprehensive neuropsychiatric evaluation
• Use of optimal pharmacotherapy, guided by evidence-based principles
• Ongoing primary care evaluation, treatment, and follow-up
• Ongoing evidence-based psychosocial therapy
• Family involvement and therapy (HIPAA regulations must be revised to allow this for disabling disorders such as SMI and stroke)
• Avoid jailing psychotic SMI persons by: preventing relapses with judicious, more widespread use of long-acting injectable antipsychotic medications, hospitalizing them in maximum security units instead of incarcerating in a nonmedical, criminal justice setting
• Ongoing diet and exercise counseling
• Cognitive remediation
• Vocational rehabilitation, including help completing high school and college for patients whose first episode interrupted their education
• Long-term beds for SMI patients who are incapable of independent living because they are severely disorganized or treatment-resistant or -refractory
• Outpatient commitment to ensure continuous monitoring and access to treatment and earliest possible intervention in the event of impending psychotic relapse or suicidal or homicidal ideation
• Aggressive addiction treatment, rehabilitation, and prevention
• Social therapy: eg, group, music therapy, recreational therapy, and group activities in sports or table games to establish friendships
• Continuity of treatment so that SMI patients receive care from the same psychiatric team for as long as possible
• Use of rating scales to measure severity of illness or the degree of response to treatment, or to assess social and vocational functional capacity
• Encouragement of SMI patients to volunteer in clinical trials conducted to develop new treatments or discover biological causes and biomarkers of disease
• An increase in funding for research on the neurobiology, treatment, and prevention of SMI
• Special investment in unmet needs of SMI patients, such as treatment of negative symptoms and cognitive deficits
• Intensive public education to obliterate stigma and foster the same compassion for SMI patients that stroke patients are offered

HIPAA: Health Insurance Portability and Accountability Act; SMI: severe mental illness

vide the necessary components of a therapeutic placenta. It should not be surprising to witness the terribly stressful life and premature mortality of SMI patients, who are modern-day *les misérables*.

The ***Table*** lists what I consider to be the necessary spectrum of health care services through the life of an SMI patient that an optimal therapeutic placenta *must* provide until an effective prevention or a cure for SMI is discovered.

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Reasons to be hopeful

Admittedly, encouraging steps are being made toward establishing a therapeutic placenta for SMI:

The RAISE Study[3] **and Navigate Program**[4] demonstrate that implementing a comprehensive program of acute treatment and psychosocial interventions and rehabilitation yields better outcomes in SMI.

The Institute of Medicine released a landmark report on psychosocial interventions for mental illness and substance abuse disorders. It outlines a new model for establishing the effectiveness of intervention and the implementation of psychosocial strategies in clinical practice.[5]

The 21st Century Cures Act, if passed by Congress and signed by the President, will increase funding for the National Institutes of Health, which in turn will bolster the budgets of the National Institute of Mental Health, National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism and enhance the chances of discovering better treatments and prevention of SMI.

The Helping Families in Mental Health Crisis Act, more directly relevant to mental health and psychiatry, proposes, if passed, to:

- enhance evidence-based and scientifically validated interventions in the public sector
- raise the profile of mental health within the federal government by creating a position of Assistant Secretary for Mental Health in the U.S. Department of Health and Human Services, who will have oversight of both research and mental health care within the federal government.

Unacceptable disparity must be remedied

Planning an effective therapeutic placenta is imperative if health care for SMI patients is to approach the comprehensive spectrum of treatment, rehabilitation, and prevention available to stroke patients. Although stroke is regarded as a sensory-motor brain disorder, it is also associated with mental symptoms, just as schizophrenia is associated with sensory-motor symptoms. Both are disabling brain disorders: one, physically and cognitively; the other, mentally and socially. Both require a therapeutic placenta: Stroke is supported by one; schizophrenia is not. This is an unacceptable disparity that must be addressed—soon.

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Editor-in-Chief

An effective therapeutic placenta is imperative if health care for SMI patients is to approach the spectrum of care available to stroke patients

See this article at **CurrentPsychiatry.com** for a look at Mayo Clinic guidelines for stroke management

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Box

Mayo Clinic offers guidelines for managing stroke

Where is care provided?
Intensive care unit → hospital ward → inpatient rehabilitation → outpatient follow-up and rehabilitation → skilled nursing facility → home-based programs
Who provides care?
Neurologists, psychiatrists, primary care physicians, hospital nurses, rehab nurses, physical therapists, occupational therapists, speech and language pathologists, dietitians, social workers, psychologists, recreational therapists, vocational counselors
What rehabilitation services are offered?[a]
Physical activities (motor skills, mobility training, range of motion therapy, constrained-induced therapy)
Technology-assisted physical activities (functional electric stimulation, robotic technology, wireless technology, virtual reality, non-invasive brain stimulation)
Cognitive and emotional therapy (for communication disorders, psychological evaluation and treatment, medications)
Experimental therapy (eg, stem cells or alternative therapies such as massage, herbal therapy, and acupuncture)

[a]Rehabilitation might start 24 to 48 hours after a stroke, during the acute hospital stay, and continue for months or years