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Access to Psychiatric Medications in Unhoused Populations: Implications for Hospitalization and Readmission Rates

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Abstract

Persons experiencing homelessness (PEH) face disproportionately high rates of psychiatric illness and hospitalization, with mental illness prevalence reported as high as 76.2%—significantly higher than in the general population. Psychiatric treatment for PEH is often hindered by systemic barriers to care, including medication nonadherence stemming from fragmented healthcare delivery, stigma, transportation challenges, and unstable housing. This discontinuity contributes to elevated readmission rates, with studies showing 30-day psychiatric readmission rates up to 2.04 times higher for unhoused individuals. Medication access is further complicated by inappropriate prescribing patterns and difficulty in maintaining treatment regimens for chronic mental illnesses such as schizophrenia and bipolar disorder. Multifactorial barriers—spanning patient-level, treatment-related, and structural factors—worsen adherence. Evidence-based interventions such as Assertive Community Treatment, Customized Adherence Enhancement with long-acting injectables, and Housing First models have shown success in improving treatment continuity and reducing psychiatric symptomatology. Emerging solutions like street medicine and mobile outreach deliver low-barrier care directly to shelters and encampments. Addressing psychiatric medication adherence among PEH is not only a clinical priority but a public health imperative, requiring integrated, compassionate, and housing-informed care models.

Keywords: Psychiatry, Unhoused, Medication Adherence

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1. Introduction

Access to psychiatric care is an important factor for mental health outcomes, yet there are significant disparities among unhoused populations. Persons experiencing homelessness (PEH) are disproportionately impacted by psychiatric disorders with studies finding a reported prevalence as high as 76.2% for any mental illness, much higher than within the general population (1). Effective treatment for psychiatric disorders often relies on sustained access to medications which may be frequently disrupted for PEH. There are several barriers to access including disconnected healthcare delivery, limitations in transportation, stigma, and unstable housing which all compound to exacerbate mediation nonadherence. These issues are exacerbated by discontinuity in care leading to worsening psychiatric symptoms, increased reliance on emergency services, and higher hospitalization and readmission rates (2-4).

2. Discussion

Psychiatric Readmission for PEH

PEH with psychiatric disorders face disproportionately higher rates of hospitalization and readmission, potentially driven and worsened by unmet treatment needs and limited outpatient follow-up. A retroactive study found that 30-day psychiatric readmission rates occurred within 42.8% of unhoused patients compared to only 19.9% for matched patients with secured housing (4). Other similar studies have found readmission rate discrepancies for unhoused patients were 22.2% compared to only 7.0% for matched and securely housed controls (3). A cohort analysis of 3907 PEH discharged from psychiatric hospitals revealed that 70% had severe mental illness. Adjustments made for covariates displayed that individuals had a 2.04-fold increased risk of 30-day readmission and a 1.65-fold increase at 90 days (2).

Medication nonadherence and limitationstherein may play a central role in these outcomes. Psychiatric medications such as antipsychotics, mood stabilizers, and antidepressants effectively reduce symptom relapse and hospitalizations, though they often require consistent use and close monitoring. Unhoused patients with schizophrenia or bipolar disorder experience high rates of potentially inappropriate prescription – up to 88.4% in one study – or no appropriate prescription at all (5). Failures in providing effective treatment may exacerbate the psychiatric symptoms and reinforce the detrimental cycle of hospitalization and institutional care for patients.

Barriers to Medication Adherence

There are several interrelated factors that contribute to the increased rate of behavioral health medication nonadherence in PEH. Factors include patient-related challenges (cognitive impairment, substance use, mistrust in healthcare), pharmacotherapy-related issues (detrimental side effects, lack of long-acting medications) and social determinants (income insecurity, lack of medication storage) (6). Patients with a post-traumatic stress disorder (PTSD) diagnosis were less likely to have nonadherence identified – potentially due to underreporting and reluctance from individuals to self-report their nonadherence or diagnosis (6). Mental health services are critical for the success of psychiatric treatment. Factors leading to improved care, medication adherence, and length of homelessness include receipt of primary care, care from a mental health specialist, and receipt of long-acting injectable antipsychotics (7, 8).

Interventions and Evidence-Based Solutions

Intervention strategies aimed at improving mediation access and adherence among PEH must be multifactorial. Models such as Assertive Community Treatment, Customized Adherence Enhancement combined with Long-Acting Injectable medications, and Housing First have shown strong evidence for improved psychiatric medication adherence (9). Common themes within these interventions rely on the combination of follow-up services and improved healthcare delivery, which allow them to be well-suited for individuals facing housing instability.

Notably, the Housing First programs are particularly of interest in benefiting these patients as they provide immediate access to stable housing without typical preconditions such as sobriety or compliance with treatment. Introduction and maintenance of stable housing environments has been associated with both better medication adherence as well as a reduction in psychiatric symptomatology. Stabilization of psychiatric symptoms can facilitate improved engagement with other social services and the health care systems, paving a path for long-term recovery.

The reality of the daily experiences that PEH faces both require and deserve specialized approaches

to healthcare delivery which bridge treatment and care for mental, behavior, and substance use disorders. Street medicine and mobile psychiatric outreach are examples of emerging modalities which effectively bring this care to PEH in low-barrier environments such as shelters and encampments. By meeting people where they are, these programs can help overcome barriers to care (10).

3. Conclusion

Unhoused persons living with psychiatric illness represent a population at a crossroads between healthcare, housing, and social service failures. Elevated prevalence within psychiatric conditions among this population in conjunction with heightened hospitalization and readmission rates are driven in part by poor access and adherence to psychiatric medication and fragmented continuity of care. Interventions show promising success in improving access to psychiatric treatment, including long-acting formulations of medications, low-barrier clinics, and integrated care models. These interventions reduce hospitalizations and promote greater housing stability. Bringing to light psychiatric medication adherence among PEH must be viewed as an important clinical concern as well as a broader public health issue.

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