How Health Reform is Recasting Public Psychiatry

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KEYWORDS

- Community mental health • Public psychiatry • Health care reform
- Integrated behavioral health care • Managed behavioral health care
- Involuntary treatment • Telepsychiatry

KEY POINTS

- Milestones in the history of public psychiatry explain how health care reform is transforming the field through changes in financing, clinical integration, and care management.
- New features of community mental health include changing patient populations, increased importance of psychiatric consultation to primary care, telepsychiatry, practice in health homes, and greater participation in managed care.
- The future of public psychiatry encompasses new funding streams, collaboration in integrated health systems, evolving roles for recovery principles and involuntary treatment, and further academic partnerships.
- Public psychiatry leadership must help guide health care reform, emphasizing access to quality care, promotion of recovery and social engagement, and active participation in policy development.

INTRODUCTION

This article reviews ways that the fiscal, programmatic, clinical, and cultural forces of health care reform are transforming the work of public psychiatrists. Reform was

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spurred by the fact that health care consumes some 17% of the national gross domestic product of the United States, yet provided relatively poor outcomes and left 40 million people uninsured. In addition to expanding access to care, the intent of health care reform is to achieve the triple aim of better health outcomes, improved quality and experience of care, and reduced costs.[1]

Tenets of health care reform, namely, increased access, parity, primary care–focused service integration, accountability with risk-bearing payment arrangements, and outcomes-driven treatment, arguably transform psychiatric practice more than other medical specialties, given psychiatry's enormous dependence on government funding.[2] Public psychiatry, long embedded in mental health systems essentially untethered from physical health care structures, has been especially upended as health care reform has occurred during an era of fiscal austerity in the face of increased service demands, corroding the midcentury foundations of community mental health. Public psychiatrists are challenged to create new practice models that respond to novel demands and preserve cherished values.

While recognizing variations of public psychiatric practice, this article focuses on public psychiatric activities practiced in community mental health systems by physicians supported directly or indirectly by governmental funding. Given the large funding roles of Medicare and Medicaid, this focus encompasses a sizable fraction of working psychiatrists.

Exciting new applications of public psychiatric practice in integrated primary health care environments and population health management are emerging.[3] Simultaneously, there is an opportunity, perhaps fleeting, to imbue a freshly minted health care system with therapeutic ethics that public psychiatry has long nurtured in sometimes unhelpful isolation. Effectively seizing this moment requires an understanding of key history, emerging psychiatric practices in safety-net systems, and some major issues for the future of public psychiatry.

A RECENT HISTORY OF PUBLIC PSYCHIATRY IN THE UNITED STATES

Public psychiatrists developed their identity as "community psychiatrists" in the clinical environments codified by the federal Community Mental Health Centers Act of 1963.[4] Freed from the confines of state hospitals, they now worked closely with community social agencies, local public hospitals, and associated academic institutions. Their clinical skills broadened to include more psychotherapies, and consultation and liaison psychiatry. Their contributions to the academic literature enhanced the scientific rigor of the subdiscipline.

Unfortunately, the transition from state hospital to community clinics was hampered by underplanning and underfunding.[5] The most severely mentally ill had more difficulty accessing treatment than did less severely affected patients seeking psychotherapy. Alliances with local general health systems often led to unfairly low budgets for mental health treatment, fueled by stigmatization of mental illness. Advocates successfully campaigned to separate administrative, programmatic, and fiscal supports for public mental health from those for the general health system.

This separation sometimes led to remarkable gains in community mental health services in general, but the effects on public psychiatry were profound. Public psychiatrists lost some previous connections with academia, general medical systems, and general psychiatry, and the decreased medical focus of the carve-out led to loss of many of their administrative functions.[6] Clinical practice narrowed, with prescribing eclipsing psychotherapy. The growing importance of empowerment and social support as mainstays of community treatment were occasionally contrasted with a