From Alienism to ACOs: Integrating Psychiatry, Again

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This column describes the gradual integration of psychiatrists into mainstream general medical care, from their exile as "alienists" in isolated asylums to their current roles in accountable care organizations. The authors note that a contemporary form of alienism persists and argue that conceptual parity—the idea that mental illnesses exist within the same ontological realm as other illnesses—must first be achieved before full integration can be realized. Some steps toward achieving conceptual parity, such as the development of quality measures for behavioral health care and improved training programs, are described.

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Over the past century and a half, psychiatry has gone through periods of disconnection from somatic medicine and the larger health care enterprise. These disconnects were the result of professional specialization, fragmentation, differences in theoretical orientation, and the prevailing view that mental illness is categorically different from bodily illness. Many of these factors continue to undermine efforts to reach the goal of integration and true parity for behavioral health care—a goal set out explicitly in 2003 by the President's New Freedom Commission on Mental Health (1).

As empirical evidence about the causes of and treatments for mental illness rapidly accumulates and as the policy stage rewards integrated care, there is no better time to try to close these gaps. Moreover, integrating psychiatric care is an ethical and policy imperative, because it promises dramatically better clinical outcomes, cost savings, and long-term sustainability (2).

But significant practical and theoretical obstacles remain. Mental illness will continue to be cordoned off from general medical illness in the way it remains moralized and stigmatized in the minds of health care providers and policy makers. A much deeper kind of parity—what we refer to as conceptual parity—must first be achieved before full integration is realized.

The New Alienism

For most of the late 19th and early 20th centuries, psychiatric care was provided far away from metropolitan centers. Asylums were disconnected from the mainstream, and psychiatrists working in them—sometimes called "alienists"—were overseers and superintendents as much as clinicians. Psychiatric research during this period was stagnant, and psychiatrists continued to drift away from the medical profession (3). As such, psychiatry became both physically and intellectually alien to other specialties of medicine—where advances were happening at a breakneck pace. Meanwhile, neurologists and so-called psychological physicians labored to treat "nervous patients" in academic medical centers. These professionals considered themselves completely distinct from the psychiatrists working in the far-off asylums. Lines of communication between psychiatrists and other specialists were indirect, and their patients rarely were cross-referred.

After World War I, specialists in psychological medicine saw the value in situating psychiatrists within academic medical centers and general hospitals, in part because of an influx of combat veterans who presented with "shell shock" (4). By 1930, the seeds of psychosomatic medicine were sown, developing into the specialty of consultation-liaison psychiatry. Through the 1930s and 1940s, increasing medical costs, declining hospital censuses, evidence of improved patient outcomes, and the need for better educational opportunities led general hospitals to begin admitting more psychiatric patients. Philanthropic organizations—particularly the Rockefeller Foundation under the leadership of Alan Gregg—provided the necessary and enormous sums of money needed to establish psychiatric training centers and clinics within general hospitals (5). Today, all major hospitals employ psychiatrists, who work closely with medical teams as experts in capacity evaluations, medication management and compliance, and the treatment of co-occurring mental disorders.

Despite these steps toward integration of psychiatry in medical centers, a contemporary form of alienism persists. Psychiatric electronic medical record systems remain firewalled from other specialties, some psychiatric diagnoses are intentionally obfuscated in patients' charts, insurance

coverage for mental health care remains carved out and disparate, meager reimbursements are often onerous to obtain, wait times are exceedingly long, and strict and often-misunderstood privacy laws make it difficult to communicate with a patient's family members when crisis strikes (6,7). The result is that psychiatry continues to be stovepiped within today's health care system.

Opportunities and Obstacles

Accountable care organizations (ACO), created by the Affordable Care Act, encourage many of the reforms required to integrate psychiatric care with traditional general medical care. The shared savings benefits and prospective payment provisions built into the ACO payment structure create an incentive to effectively manage patients with comorbid mental and general medical illnesses and substance use disorders—a high-risk and expensive population (8). Payment reform now makes previously prohibitive investments in innovative care delivery possible. New integrated care models rely heavily on behavioral health paraprofessionals for patient communication and care coordination, utilize technologies to track patients electronically, and incorporate telemedicine for improved access to behavioral health specialists. Further steps could involve online medication management sessions and computer-assisted cognitive-behavioral therapy.

For example, the Missouri community mental health centers are pioneers in integration. Their teams are led by nurse case managers and supported by primary care doctors and psychiatrists, and community support specialists manage eligible patients with severe mental illness and general medical illness. The centers utilize a comprehensive electronic health record to enhance communication and advanced data analytics to identify higher-risk patients. Not surprisingly, the Missouri program boasts improvements for enrollees in independent living, legal involvement, psychiatric hospitalization, and overall health care costs. Likewise, in New Jersey, the Camden Coalition Accountable Care Organization uses sophisticated data sets to identify and provide intensive services to "super utilizers"—many of whom have unstable housing situations and substance use and mental disorders—to reduce use of the emergency department and inpatient care. Such models consistently demonstrate improved outcomes and lower costs (8).

Regrettably, the lack of quality metrics for behavioral health care outcomes has slowed the development of ACOs. Among the 33 core metrics that are tied to ACO accreditation, there is only one quality metric for behavioral health care—depression screening—which in many studies has not been shown to substantially affect health (9). Of the hundreds of quality measures available, only 10% align with the Substance Abuse and Mental Health Services Administration's National Behavioral Health Quality Framework, and no behavioral health measures are included in the Medicare and Medicaid EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals (10). Moreover, in many areas, payer carve-outs and separate billing requirements hamper payment reform efforts and sharpen the divide between behavioral and general medical care (11).

Issues of cost and quality become particularly salient in the care of patients with severe mental illness, such as schizophrenia or bipolar disorder, and comorbid general medical illness. Effective management of these patients requires an intensification of services, including case management, housing, community support, and institutional long-term care (12). But unless quality measures are implemented and providers are rewarded for the high-quality behavioral health care they deliver, there may be an incentive to deselect such patients, further marginalizing this already underserved population (13). In addition, restrictions such as Medicaid's exclusion for institutions for mental diseases—which has curtailed the creation of new psychiatric beds—continue to limit access to appropriate psychiatric care and are currently targeted for reform in proposed federal legislation (14).

Conceptual Parity is Essential

Opportunities for integrated psychiatric care can be realized in practical terms. New legislation and policies can drive and provide incentives for the colocation of mental health professionals with other specialists, new clinical practice guidelines can stipulate the importance of behavioral health care in treating general medical illnesses, and new training programs can be launched. Developing validated evidence-based quality measures to assess care of complex cases will both promote integration and improve efficiency (15). However, these operational improvements, while necessary, will not be sufficient without a radically transformed understanding of mental illness as simply "illness."

Conceptual parity is a genuine commitment to the ideal that mental illnesses exist within the same ontological realm as other illnesses. This does not mean that mental disorders are identical to other illnesses. Instead, it means that they are fundamentally harmful dysfunctions of the "brain-mind" that are medically responsive and remediable (16). Bipolar disorder, for example, should be viewed as a chronic, manageable disease similar to diabetes, not as an intractable or inevitably disabling condition. Thus the ideal of conceptual parity must be achieved not merely in the provision of equal access to treatment—more fundamentally, it must exist in the minds and be expressed in the language of health care providers and the public.

Conceptual parity can be realized through long-term sustained efforts in research, education, and treatment. Discoveries in the biological etiology and advances in psychopharmacological treatments for serious mental illnesses, such as schizophrenia and bipolar disorder, will provide opportunities to roundly reject the myth that these illnesses are nothing more than moral failings or personal eccentricities.

Providing sorely lacking educational opportunities for medical students and trainees that include longitudinal direct contact with individuals with serious mental illness will be essential. Allied health professionals should receive training in behavioral health care and the special considerations in the care of those with mental illness. Newly trained cadres of primary care behaviorists—clinicians able to synthesize and treat biopsychosocial signs, symptoms, and complaints—will signify the embodiment of integration (17).

Only conceptual parity—the realization that there is no health without mental health—will silence the ideologies that once alienated psychiatry to the bucolic pastures of the past and that continue to segregate mental health care in our modern clinics.

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Correction to Freidl et al.

In the article "Effects of Clinical Decision Topic on Patients' Involvement in and Satisfaction With Decisions and Their Subsequent Implementation," by Marion Freidl, M.D., et al., published in *Psychiatric Services* in Advance on February 15, 2016, the name of a coauthor was listed incorrectly. The correct name is Corrado De Rosa, M.D.

The name has been corrected in the article published in *Psychiatric Services* in Advance and will be listed correctly when the article is printed in the June 2016 issue.