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**Brief History of Social Psychiatry**

Perhaps the first indication of the importance of social psychiatry came in the form of the "moral treatment" for hospitalized psychiatric patients in Europe at the turn of the 19th century. This movement provided evidence that a change in the inpatient environment and more humane social interactions produced an improvement in patients' functioning. The importance of social psychiatry became even more obvious in the United States at the beginning of the 20th century with the work of Adolf Meyer, M.D. He became well-known for emphasizing many important social factors, including studying the whole individual, constructing life charts of major events in a patient's life and integrating social work into psychiatric treatment settings (Brady, 1975).

Many American psychiatrists and other mental health professionals followed in Meyer's footsteps, writing major texts on various aspects of social psychiatry. Among them, Karen Horney, M.D., wrote about personality in terms of "toward," "against" and "away from" other people (1937); Erik Erikson discussed societal influences on life development (1950); Harry Stack Sullivan, M.D., reviewed interpersonal psychotherapy (1953); August Hollingshead, Ph.D., and Fredrick Redlich, M.D., revealed social class influences on the provision of psychiatric treatment (1958); and Alexander Leighton, M.D., explained the influence of social disintegration on the development of mental illness (1959).

World War II and the surprising number of psychiatric casualties from trauma made the influence of social stress more apparent. The success of crisis resolution on the war front and in other outpatient interventions, along with a moral concern over hospital warehousing, led to deinstitutionalization and a new social system of care in the guise of the community mental health care movement of the 1960s.

In general medicine, attention to social variables was admonished by Hippocrates, with his concern for the total human in his or her total environment. This perspective crystallized in 1977 in the work of George Engel, M.D., who wrote a classic article emphasizing a biopsychosocial paradigm instead of biomedical reductionism. Of all the medical specialties, psychiatry seemed to pay the most attention to this model.

In 1971, American psychiatrists who were giving special attention to the social part of the model started the American Association for Social Psychiatry (AASP). By the 1980s, social factors had a presence in our *DSM-III* in the Axis IV and V categories. American Psychiatric Association presidents (Fink, 1988; Hartmann, 1992) intermittently reminded us of the importance of the integrated biopsychosocial model.

**Social Psychiatry in the 1990s**

With the burgeoning recognition of the influence of social factors on the prevention, etiology, access, diagnosis, treatment and repercussions of mental disorders, social issues continued to receive attention in the 1990s. Many of these issues were discussed in a major international conference and in a reference book on social psychiatry (Sorel, 1993). Advances occurred in psychosocial rehabilitation techniques, addressing homelessness, reducing stigma, increasing clinical cultural competence, attention to trauma, services in jails and prisons and successful advocacy groups, among other things.

Add to these social psychiatric achievements the continued refinements of psychotherapies and the striking advances of biological psychiatry in the form of helpful new medications, and one would expect psychiatry to be in a golden age. But it is not. Why?
The New Millennium

With the availability of new treatments and better insurance coverage, most of psychiatry-including social psychiatry-seemed to forget about the social ramifications of costs. The unexpected rise of general health care costs at the turn of this decade was a major concern of business and governmental payers, and the costs were rising even more dramatically in mental health care. Cost concerns were coupled with a lack of accountability as evidenced by overutilization, perfunctory peer review and wide variations in quality of care, and the groundwork was laid for managed behavioral health care systems-often carved out from general health care-that could reduce costs and monitor outcomes. To do so, the business practices of managed care companies introduced new industrial administrative processes and a concern with profit margins. Whatever the successes of managed care, the remaining social problems are well apparent. The number of uninsured individuals, already in the millions, is still rising, and millions more need psychiatric care but are not receiving it. Prevention is still a promise, quality of care is questionable, behavioral health care continues to be separated from the rest of health care, and the morale of clinicians is plummeting. A new report issued by the National Center on Health Statistics found that poorer and less educated people suffered more from virtually every health problem, and died earlier. If we honestly examine the strengths and weaknesses of our prior fee-for-service and public sector systems, different managed behavioral systems and other systems of care around the world, perhaps we can come to a better consensus of what is needed to combine the best of business and health care ethics (Moffic, 1997). A 10-point millennium plan might include:

1) Universal coverage for humane, adequate and competent care of all people.
2) A single payer that would develop uniform administrative principles.
3) Management of care that would reduce overutilization, underutilization and variations in quality of care.
4) A biopsychosocial approach using evidence-based guidelines.
5) Integration of psychiatry with the rest of medicine.
6) Prevention whenever possible.
7) Outreach to those needing psychiatric treatment but not receiving it.
8) Clearer roles for all mental health disciplines.
9) Reimbursement based at least in part on cost-effectiveness and outcomes.
10) Reduction of sociocultural discrimination of patients and clinicians.

Not long ago, a psychiatrist at an AASP meeting commented that social psychiatry "does not hit my pocketbook." To the contrary, ignoring costs and accountability has affected all of our pocketbooks in one way or another. Paying attention to cost-effectiveness in our individual patient encounters and in our systems of care is crucial for the new millennium. The social psychiatric perspective should help us to do so in a fair way.

References:

References

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