BEHAVIORAL HEALTH NEWS

FALL 2013

"BEHAVIORAL" HEALTH: WHAT A DIFFERENCE A WORD MAKES!

By

Michael B. Friedman, MSW

Mental Health News is now *Behavioral Health News*. It has also reached out to the fields of alcohol and substance abuse services and has expanded its subject matter to include information about these fields in addition to the field of mental health. This is an exciting development that, I think, will enable *Behavioral Health News* to serve as a platform for discussions of vast changes in public policy that are now underway.

The name change obviously follows a trend that has gathered momentum over the past decade for "mental" health organizations to become "behavioral" health organizations. For example, The National Council of Community Mental Health Centers is now The National Council of Community Behavioral Healthcare, and The Coalition of Voluntary Mental Health Agencies is now the Coalition of Behavioral Health Agencies.

Why is this shift in terminology taking place? Let's start with a bit of history.

Until the 3rd quarter of the 20th century "mental health" referred to all diagnosable mental conditions, including addictive disorders and, arguably, developmental disabilities. For example, until the mid-1970's there was a single Department of Mental Hygiene in New York State. It was responsible for services for people with mental illness, "mental retardation" (as it was known at that time), alcoholism, and addiction to illegal substances. In 1977, this department was divided into four cabinet level departments—the "Offices" of mental health and mental retardation and the "divisions" of alcoholism, and substance abuse, which were subsequently merged into an Office of Alcoholism and Substance Abuse. http://www.archives.nysed.gov/a/research/res_topics_health_mh_recguide_dmh.shtml

Similar restructuring took place around the country, reflecting changes that had already taken place in the field. Families of people with intellectual and developmental disabilities (as they are now known) worked hard to get out from under the control of psychiatry and other mental health professions. They did not regard developmental disabilities as mental

illnesses and had little regard for the usefulness of mental health professionals for their family members.

The fields of alcoholism and substance abuse also worked to get out from under the control of psychiatry and other mental health professions. By the 1970s there were profound differences between the views, practices, and personnel of "mental health" and those of alcohol and substance abuse services. One difference was that mental health practitioners by and large were professionals with university degrees and other formal professional training and credentials. The dominant providers in the field of addictions were recovering alcoholics and drug addicts who believed that professionals were not only not necessary but were also potentially harmful. Why? Because mental health professionals tended to believe that treatment should either be an effort to uncover the inner psychological root causes of addiction or should involve providing medication, while addiction providers generally believed that behavior had to be changed immediately with the help of other people with addictions and a higher power. They also were generally opposed to using substances to treat substance abuse. Immediate abstinence was their fundamental goal.

We tend to talk these days about the "silos" of mental health and substance abuse as if this was just some dumb thing that happened thoughtlessly, but in truth the silos (a metaphor I have never understood) reflect the profound disagreements that existed, and to some extent still exist, between mental health professionals and the people who led efforts to address substance abuse—whether alcohol or illegal substances.

The schism between the fields of mental health and substance abuse worked out pretty well in the politics of public policy and public service, but it was not an idea that captured the minds and hearts of large employers and health insurance companies that needed to make decisions about the extent to which they should cover mental as well as physical conditions. To them an addiction was a mental health condition—if it was a health condition at all.

By the early 1980s managed care organizations were beginning to develop a market among employers and health insurance companies for the management of access to mental health services, including services for addictions. As far as I know, it was these companies that coined the term "behavioral health".

At that time, I was Director of Operations at The Jewish Board of Family and Children's Services and helped the agency create a managed care division. To us and to other

companies, "behavioral" health was a term that served two purposes. First, it referred to both mental and addictive conditions, indicating to potential customers that we would take care of both kinds of problems. Second, it emphasized the importance of behavioral change at a time when mental health professionals were perceived (fairly or not) as Freudians who would let people lie on the couch for years without any change in behavior. Neither employers paying for health coverage nor health insurance companies trying to keep costs predictable wanted employees or their families in endless treatment that produced no improvement in the behavior that resulted in lost productivity. They wanted treatment to be short-term, focused on documentable behavior change, and in the community rather than in hospitals whenever possible. This is what managed care promised; and despite widespread criticism from traditional providers, it appeared to be effective.

By the early 1990s the public sector had been drawn to the idea of behavioral managed care, and it became a core element of the push for Medicaid managed care. Grand visions to the contrary and with exceptions in a few states, early Medicaid managed care used behavioral managed care organizations primarily for people on Medicaid who were not seriously and persistently mentally ill (SPMI).

During this same period, there was increased awareness that a great many people with serious mental illness also had substance use disorders and vice versa. It was clear to almost everyone that these people needed treatment for both disorders and that at the very least providers from the two silos should coordinate treatment or, better yet, that providers with expertise in both types of disorder should provide integrated treatment for people with co-occurring disorders.

As a result, some mental health organizations that had not provided substance abuse services began to provide them, and governmental mental health and substance abuse authorities that had stayed largely out of each other's business talked more and more about cooperative arrangements or even mergers.

According to the National Council of Community Behavioral Healthcare, these developments led to its name change. "As services offered to the mentally ill became more diverse and comprehensive, it also became clear that helping people function at optimal levels would require the addition of treatment services for addiction disorders. This coordinated brand of service was labeled as "behavioral healthcare" — and providing comprehensive behavioral healthcare services is the goal of community-based organizations today." http://www.thenationalcouncil.org/cs/history

Substance abuse organizations also had changed. Some were prepared to provide mental health services; and many had largely professionalized. The personnel of the fields of mental health and substance abuse were increasingly similar in professional background.

It also became clear that providers who were struggling to survive efforts to contain Medicaid and other costs would have greater political clout if they worked together. This was another important reason why some trade associations shifted to calling themselves "behavioral" health organizations.

In short, the use of the term "behavioral health" emerged from a combination of the growth of behavioral managed care, the effort to integrate care for people with co-occurring mental and substance use disorders, changes in personnel, and the political advantages of cooperation rather than competition.

General health care reform and especially the passage of the federal Affordable Care Act have provided additional reasons to think in terms of "behavioral" rather than "mental" health. Health care reform calls for the development of comprehensive service organizations with high levels of coordination. Health care models such as "medical homes," "health homes", and "accountable care organizations" presumably will become the primary vehicles for health, and perhaps behavioral health, service delivery. By coordinating care and particularly by integrating physical health and behavioral health services, they are expected to improve the quality of services, improve health status of Americans, and to hold down costs.

In addition, the effort to control Medicaid costs has focused particularly on people who have co-occurring serious mental, substance use, and physical disorders because they are generally the highest cost cases and are the most likely to have long-term disabilities and to suffer premature mortality. Medicaid, in New York State and elsewhere, has turned to behavioral health managed care organizations to make sure that people on Medicaid get the services they need in the community and use inpatient treatment as little as possible. That is just an interim measure, however. Over time, Medicaid managed care is supposed to become comprehensive, covering people with both behavioral and physical health disorders, including those with SPMI.

In essence, general health care reform and the effort to contain Medicaid spending create powerful economic incentives for mental health and substance abuse providers to join forces as a business and political strategy and as a way to improve the quality of care.

Given these trends, it is pretty clear that the concept of "behavioral health" is here to stay for a while. And, by including substance abuse providers among its sponsors and authors *Behavioral Health News,* née *Mental Health News*, will be in a far better position to foster the integration of mental health, substance use, and physical health care services that is a fundamental goal of health care reform.

I look forward to having *Behavioral Health News* as the observer of the vast changes already underway, a source for constructive critics to voice their concerns publicly, and as a vehicle of cooperation among providers who have historically been divided against each other.

(Michael B. Friedman teaches health and mental health policy at Columbia University. He can be reached at mf395@columbia.edu. His writings are at www.michaelbfriedman.com.)