Behavioral Health: Where Have We Been, Where Are We and Where Are We Going?

Richard Cohen 24 April 2014

In the Spring 2014 edition of the *Stanford Social Innovations Review*, Dr. Robert Ross, the President and Chief Executive Officer of The California Endowment, and a one-time Health Commissioner of Philadelphia and Public Health Management Corporation Board member, said in a lead article, "Innovation has been critical to economic and social progress since the invention of the wheel. But innovation isn't everything. In fact, when it comes to addressing today's urgent social problems, from education and public health to civil and human rights, innovation is overrated. The greatest impediment to solving these problems is not a lack of innovation. Rather, it is our inability to scale up solutions that we know work."

This article and, in particular, this quote, have generated a firestorm of important discussion, much of it focused on the public health arena. Relevant to this discussion, it is suggested that services in response to behavioral health issues might best be looked at, reviewed and debated within the context of Dr. Ross's concern.

Since the community mental health movement of the late 1960s, the behavioral health, prevention, treatment and services system across the United States has gone through a number of waves of change. Certainly, the growth of community mental health centers, principally in the 1970s, offered the first broad availability of treatment for populations significantly in need. Within the sub-context of the heroin epidemic of the 1970s, the growth of the substance abuse prevention and treatment system was robust and changed the dynamic of addiction across the country. Shortly after the zenith of this wave, deinstitutionalization swept across the nation, often resulting in a perverse mix of positive and negative consequences both for individuals and society. More recently, the recovery movement has taken precedence throughout the behavioral health system and has offered an array of changes. Succinctly, over the past 50 years, behavioral health has faced repeated new innovation and its face continues to change.

Has there been enough discussion about this change? Have we used good science to evaluate the impact and outcomes on our communities, on our society and on the impacted individuals? Other topics within this discussion are “no go” areas with any robust research off limits to serious scientists. We consistently discuss “evidence-based” treatment, and yet the evidence in many cases remains very limited and often not peer reviewed. In effect, evidence-based has become a mantra but not a

precise clinical practice. During this same period, many of our world-class treatment facilities and services have been dismantled, some for business reasons, others because of organizational dysfunction, but in some cases as a result of the trends of the times. Much like the appearance and disappearance of Hush Puppies as a shoe of fashion, particular kinds of treatment—and in fact, the concept of treatment itself—has come and gone based on the trends of our clinical community. We know that drugs of abuse come and go, always to return again. The same is often true of suggested forms of treatment. It is not posited that this is good or bad, but only that it is a reality. Shouldn't we as policy people, scientists and practitioners care about this and ask questions? Do not these trends call out for sound research and, maybe even more important, a rich dialogue between us where every opinion is respected and the only good outcome is the best that we can do in our field? One trend that is now pretty much accepted by everyone—certainly most readers of this paper and the *Journal*—is that behavioral health is public health.

As we read this and accept it as a clear truth, it is suggested to you that in the early 1980s, although Public Health Management Corporation (PHMC) defined substance abuse more widely as public health, there was not acceptance of even the concept, let alone the approval, of the Corporation's inclusion of service programs within the management corporation. Even the

American Public Health Association, which has had a mental health section for some time, did not find large numbers of members in this agency component until close to the year 2000, and since that time it has grown exponentially. Why does this matter? Clearly, many of these trends are related to funding, insurance coverage, mandates and the flow of federal funds. At the same time, what we call things directly relates to how we treat them. In Philadelphia, the Department of Behavioral Health was carved out of the Department of Public Health for very good reasons, mostly related to ensuring full funding for these important services. Within the context of the discussion of behavioral health as public health, a number of questions arise: Should behavioral health be a part of government public health departments? Within hospitals and health care systems, should behavioral health be separate from or a part of the health care continuum? Should there be separate departments? The same question could be asked across all types of enterprises. In asking these questions, I am not suggesting an answer but rather, again advocating that full and rich discussion could only improve our field.

As noted earlier, the treatment system in our region grew markedly following the 1960s, with an outstanding set of community mental health centers covering every part of the area. Several of the mental health centers in Philadelphia were among the earliest and best in the country and provided unquestionably fine service to the

people within their catchment areas over a number of years. Inpatient and residential settings such as the Institute of Pennsylvania Hospital, Philadelphia Psychiatric Center, Friends Hospital and many others, were historically outstanding centers of both training and care in our field. The Child Guidance Center was world renowned, for clinical training, policy, and research and services to a wide population of individuals. Many if not most of these institutions are either gone or functioning at a level well below those at their peak. Can we as a community and as professionals in the field feel good about this change and the loss of these institutions? Have they been replaced by better assets for those in need for our communities and for behavioral health public policy? Might these be an area that resonates with Dr. Ross's warning that "to innovate isn't everything"? Should we be discussing the service system that was, is or—most important—might be?

Over the past 10 years, the interpretation of physical and behavioral health is a frequent topic of discussion and so-called pragmatic innovation. Descartes in the 13th century focused on the mind/body distinction (but even then fully understood the interactive nature of these systems). Our field, as funding systems evolved, has created an integration model. The speed of this change has been more like the American development of the Acela train, slow but steady, than the various European fast trains, which focus on speed and delivery. How much attention

have we paid to the peer-review research highlighting the interconnected nature of behavioral and physical heath within every setting? In 1993, in work done by PHMC, Woodside, Cohen and Coughey published in the *Journal of Substance Abuse* an article comparing the inpatient hospital utilization rates of the children of alcoholics with the rates for other children. They looked at the impact of the treatment of the primary alcoholic on their children and on the alcoholics themselves. As might be expected, post-alcohol detoxification and treatment, the primary alcoholic patient had much lower hospital utilization and, in fact, was healthier than prior to treatment. What was not as directly expected was that the children of alcoholics subsequent to the treatment of their parents also had lower inpatient health care utilization and were healthier. The alcohol behavioral treatment not only improved the physical health of the immediate consumer/patients but also improved the health of their children. Have we learned from this and related research? What are the lessons, and what have we done? More important, one might ask, have we worked to create a separate but equal scenario? Have we truly integrated physical health into our behavioral programs, and vice versa? Or, rather, have we worked to develop a shadow system that maximizes reimbursement but does not focus on the interconnected aspects of full health? Might we look to the concept of separate but equal's impact on education and virtually every other area in our society? Is this what we want? Is this best for consumers? Is this best

for our field and society? How much have these issues been discussed, and where is the peer-review research/evidence base? It must be there, so let's talk about it.

The concept of recovery and behavioral health is exceptionally important, and certainly has shown clear benefit to consumers, to communities and to our society. There is increasing research to show the benefit of recovery and the recovery movement across this spectrum. This has happened at the same time that many of our finest treatment facilities and resources have been challenged. It is suggested that throughout the health care arena, and certainly within behavioral health, there must be a careful balance between the consumer choice concept inherent in recovery and evidence-based treatment. Certainly, individuals across all health care diagnoses have the right to full information, including treatment choices and the scientific basis for the recommendation of treatment. Is it a question of individual decision at this point? At what point do the evidence, science and professional requirements of the practitioners intervene in the process of choice? When evidence suggests regular colonoscopies, should the field of medicine support a decision that a colonoscopy is not the best intervention for the intended process? When treating diabetes, what are the options presented by caregivers to restrict diet and, as necessary, insulin? Clearly, there are fine lines of distinction within these questions. At the

same time, should we be having a discussion about this balance?

In a similar fashion, patient compliance is a major topic of discussion within health care. If a provider diagnoses and treats an individual with a particular regimen, what should be that person/consumer/patient's decision-making options within that treatment? Should the provider be responsible for an individual who chooses not to comply with a suggested protocol? Again, there is no simple nor direct answer, but would this provide a useful conversation? Has there been discussion about the balance of resources and services across the treatment-recovery continuum? What does the scientific evidence tell us, and how are we engaging in a full discussion of how to achieve this balance? Do we come together to sort out a future path to best serve, or do we line up on sides and argue rather than look for answers? It is understood that this is a sensitive area, but at the same time it is suggested that it is not until we discuss this, until we discuss the best way there, that those in most need will be truly served.

Yesterday, today and tomorrow in substance abuse needs to be looked at across issues of innovation, public health, integration, treatment and recovery. Without an open and full discussion of each of these issues and the interaction across and between them, we will not enjoy the benefits of the best possible behavioral health services continuum that our field can offer and that those whom that we serve

so richly deserve. It is suggested that science, consumer input, clinical experience and, most of all a full, open, thoughtful discussion is the path to the desired outcome that we all want so much. We have made great strides in the past, and we are doing extremely good work right now. But Oh, the future with us working together and truly talking to each other could be so bright for all that we care about. Can we talk?