

ACMHA ARM CHAIR REFLECTIONS

Where Do We Go From Here? Defining Policy Priorities Post-parity

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After a long and consuming search, we have achieved parity, the behavioral health equivalent of the Holy Grail. A great and very welcome accomplishment for sure, but where to from here? What next for behavioral health policy? Is there now or is there likely to be again so dominant an issue in behavioral health, one that can once again unify the too frequent dissonance between behavioral professionals, advocacy groups, etc.?

While the quest for parity was undoubtedly and appropriately the dominant issue in behavioral health, one on which so many of us worked so long and so hard, it may also have had an unintended negative effect – too little attention paid to what may be the other important policy issues that deserve our attention. What are and/or should these be? How and by whom should they be identified, defined, prioritized, and communicated to those with responsibility to fund and provide behavioral health services?

It seems to me that there does not now exist a mechanism, a non-government entity with sufficient credibility and expertise to take all of this on. I think that ACMHA could well play a leading role here, as a sponsor of something that could be called a Council on Behavioral Health Policy. It would be similar to but of course on a much smaller scale than the Council on Foreign Relations, for example, a vehicle that has been so helpful in influencing the shaping of this country's foreign relations policies. Such a council would consist of the most highly respected and well-regarded people in the behavioral health field, with the experience and wisdom to serve on a deliberative body that could have several basic functions as follows:

- a. To discuss and describe what the council believes to be the major policy issues in behavioral health going forward and how these might be addressed.
- b. To assign priorities to these issues by virtue of their relative importance.
- c. To make policy recommendations to federal, state, and local government behavioral health entities as well as to the major professional associations and advocacy groups.
- d. As appropriate, to provide consultation to those entities as they consider and seek to implement those recommendations from the council that they deem to be worthy of their consideration.

Integration is among the policy issues that I consider to be very important but not what has become the conventional and by now tiresome use of the term, i.e., the integration of behavioral and medical care. I can think of no other single issue that has been getting more attention in the behavioral health field than has this one.

While such integration is clearly important, it seems to me it is serving as a 'Convenient Truth,' not consciously so, to distract our attention away from the significant, difficult to resolve, and long-standing integration issues within our own field. Is not the relative neglect of these behavioral health integration issues at least as damaging to good patient care as the behavioral/medical integration problems? Our behavioral health integration issues include the continuing gaps between inpatient and outpatient care, the separation both in training and service of substance use and mental health services, the rivalry and competition between the behavioral health providers of the different disciplines - trained in different places with different curricula, familiar with the research, etc., published in their own professional journals but not those of the other disciplines, etc., etc. And what about the too great distance of behavioral health from the other human services? In my judgment, too little attention is being paid to these issues, ones that we may be able to do something about and too much to medical-behavioral integration about which we can potentially do much less.

Another major issue that has been addressed from time to time by such as the Annapolis Coalition and others is the quality of the behavioral health workforce itself. I have written about this elsewhere, about the proposals and recommendations from various highly respected commissions about this issue that go back for many years and have for the most part had only a slight, if any, impact on the way the behavioral health workforce is trained – in separate enclaves, with teaching methods that are not always current, with little if any interdisciplinary training, and inattention to the changes around them, including the increased importance of consumers in treatment decisions and other societal changes.

The vested interests of the major professional associations in behavioral health supported by outdated state licensing requirements have solidified the separation of the professional disciplines from each other and enhanced the competition between them. It has also prevented or at least minimized, for example, the role that qualified properly trained advanced practice psychiatric nurses and psychologists could and should play in prescribing psychoactive medications, at least in the many areas in this country without a sufficient number of psychiatrists.

It seems to me and has seemed so for a number of years that continuing to maintain the separate disciplines in behavioral health – psychology, psychiatry, etc. – has long outlived its usefulness if in fact it was ever so. In general medical care, all physicians go to medical school before they specialize. Why should not those who choose a career in behavioral health go together to schools of behavioral health, then specialize in such as they choose in further study in substance use, child mental health, geriatrics, etc.?

Health care reform has come but reform in the way our behavioral health workforce is trained has not. It seems to me it is time to reconsider and to implement, at least on a pilot basis but hopefully beyond that, the development of a new professional discipline that combines the best of psychology, psychiatry, social work, etc., training, in one curriculum with degrees at various levels in behavioral health rather than the several disciplines. No small task I know, but in this era of reform and the changing zeitgeist, what has not been possible in the past may be more so now.