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Differing views of 'behavioral health'

In the wake of Dr. Nasrallah's recent editorial "Stop calling it 'behavioral health:' Psychiatry is much more" (From the Editor, Current Psychiatry. June 2020, p. 9-7,38), we offer an alternative viewpoint as members of a multihospital (academic and community), multifaceted, multidisciplinary behavioral health institute.

Naming a field, institute, department, or group of collaborators is crucially important, and must be undertaken with care. We all are familiar with Departments of Psychiatry, Departments of Psychiatry and Psychology, and Institutes for everything from Behavioral Health to Living. Even within the discipline of psychiatry, there have been adjustments over time in subspecialties (as seen with consultation-liaison psychiatry becoming psychosomatic medicine and then back again).

In our hospital system, we have recently adopted the term "Behavioral Health Institute" to denote the work and worth of significant numbers of caregivers (psychiatrists, psychologists, chemical dependency counselors, social workers, child life workers, advanced practice nurses, and others) who strive to improve the health and well-being of patients with both substance abuse and mental illness. We endeavor to remain mindful that a diversity of providers are involved in caring for and about our patients, and that "psychiatry" cannot—and should not—be the extent of how we conceptualize our services.

We submit that the modern view of behavioral health is ahead of other fields of medicine in recognizing that concepts, such as teamwork and diversity, are key to achieving positive patient outcomes. By identifying our providers as part of a Behavioral Health Institute, we acknowledge that not all mental distress is psychiatric illness but may still benefit from intervention and, importantly, that psychiatrists are not the center of the mental health (behavioral health) world. Treatments ranging from medication management to psychiatric procedures to psychotherapeutic modalities show the depth and breadth of our field, and the multiplicity of providers and modalities should be considered laudable. Recognizing the complexities inherent in behavioral health and its varied treatment options does not diminish but, in fact, elevates the field of psychiatry—and psychiatrists themselves.

Further, we note that behavioral health is not the only term that casts a larger net than the physician in a respective field. Does the term "primary care" insult internal medicine, family medicine, and pediatric physicians? Physicians and health care teams join in partnership with patients and families, either to cure or learn how to manage disease. We believe that constructing a health care system centered on physicians and their identities, rather than on patients and treatment outcomes, has been foolish. To that end, the tenor of Dr. Nasrallah's editorial runs counter to the overall efforts of our field to improve collaboration, and, at its extreme, such articles promote the antiquated notion of physician elitism.

The editorial's historical context is of course important, and the caution not to water down what "we" do (as psychiatrists) is appropriate. However, instead of comporting ourselves in a psychiatry-centric way, the use of the term behavioral health allows all of us to acknowledge (with appreciation and humility) the many contributors who work in our field. The use of a broad-minded, inclusive term neither minimizes nor trivializes psychiatry as a medical specialty. Rather, accepting this term and this mindset can place psychiatrists in the unique role of being innovators for the rest of medicine, because we embrace multidisciplinary teams and the value that interdisciplinary care can bring to patients and colleagues alike.

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Dr. Nasrallah responds

I thank my Cleveland colleagues for their letter, and I welcome their disagreement with the tenets of my editorial. I still insist that the term "behavioral health" has a very narrow meaning that is not equivalent to psychiatry or psychology or social work or psychiatric nursing practice. This term should not be conflated with the widely used "mental health," which is used as an overarching term for all professionals involved in the care of psychiatric brain disorders that manifest as various mental illnesses and substance use disorders.

While I am an advocate for multidisciplinary collaborations that benefit our patients, I will always uphold psychiatry as a medical specialty whose unique identity should not be sacrificed on the altar of politically correct egalitarianism of the mental health disciplines. Call it elitist if you like, but the fact is that the extensive medical school, residency, and fellowship training of psychiatrists stand out among all the other mental health disciplines. Psychiatrists are the best trained in all components of the biopsychosocial model (which I acquired many years ago from the father of the concept, George Engel, one of my teachers at the University of Rochester Residency Program).

You bring up primary care as an analogy for behavioral health. I assure you, none of the medical specialists included under that umbrella term refer to themselves as primary care physicians (PCPs) (or, God forbid, providers!). They identify themselves as family physicians, internists, pediatricians, and gynecologists. It is for the convenience of the health care systems and insurance companies that clinicians are called PCPs, which homogenizes them into a fuzzy amalgam and disguises their true medical identities as specialists.

So we agree to disagree. Diversity of opinions is a sacred principle. But I still think that a more accurate name for your Behavioral Health Institute would be "Institute of Psychiatric Medicine and Brain Health." Behavioral health, which actually refers to educating people about implementing principles of evidence-based healthy habits and behaviors that prevent or reduce the risk of mental illness and/or substance use, is a small sliver of your overall mission. As you'll notice from the other letters we've received, the vast majority of our readers agree that psychiatric medicine is far more than behavioral health.

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I thoroughly enjoyed Dr. Nasrallah's editorial and agree completely. Veterans Affairs, my employer for the last 12 years, has fully bought into the use of "behavioral health" and its implications for its many psychiatrists. I have grown very tired of the constant minimization of psychiatric practice, and it is so good to hear from an affirming voice.

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Dr. Nasrallah's editorial made my heart sing! I have been practicing psychiatry since 1979, and have always bristled when called a "provider" or any of the other terms Dr. Nasrallah described. As a graduate of Johns Hopkins Medical School, I had professors who themselves had been taught by Harry Stack Sullivan and Frida Fromm Reichman, and during my residency at the University of Chicago, I sat in discussions with both Bruno Bettelheim and Heinz Kohut. I felt part of an honorable tradition, and even though biological psychiatry was on the ascendency, these analytical luminaries were part of my learning the "art" of psychiatry. It is not so easy to feel good about a specialty that has had such a history as ours, but my own experiences could never be reduced to being called a behavioral health provider. Dr. Nasrallah's thoughts are very encouraging, and I thank him!

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Dr. Nasrallah's editorial resonated with one of my pet peeves. I've been telling my medical students for years that we psychiatrists treat disorders of thinking, emotions, and behavior associated with mental illness, and that the term "behavioral health," though possibly well intentioned, is a euphemism to reduce stigma.

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I enjoyed Dr. Nasrallah's editorial regarding "behavioral health." In New England, we have very clear delineation among psychiatry, mental health, and behavioral health. Only physicians can practice psychiatry because it is a medical specialty. Nurse practitioners and psychologists, on the other hand, are specialists in the field of mental health, as are psychiatrists, so mental health is a more encompassing term. Behavioral health encompasses all of the above plus counselors. Because insurers generally pay counselors, nurse practitioners, and psychiatrists, they use the term behavioral health because it wouldn't be right for them to pay a counselor for a psychiatric intervention. So as a psychiatrist, I respond when being referred to as a psychiatrist, mental health specialist, or behavioral health specialist. And thankfully, per American Medical Association policy, psychiatrists are not providers.

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I was grateful for Dr. Nasrallah's editorial regarding the misnomer of referring to psychiatry as "behavioral health." Until this editorial, I had wondered if I was the only one bothered by the term. Many people are under the assumption that behavioral health is a politically correct term that helps to lessen stigmatism. I completely disagree. Without question, it adds to the stigmatism. The term behavioral health is belittling to our patients. For example, calling a psychiatric inpatient unit a "behavioral health unit" implies that if patients would just change their behaviors, they wouldn't have serious biological psychiatric illness. It insinuates that the patients cause and perpetuate their illnesses, such as schizophrenia or bipolar disorder, by behaving poorly. Granted, we teach behavior modification to help manage psychiatric illness, but so, too, do our colleagues in other medical fields teach behavior modification to manage other organ-related illnesses. Some nearly ubiquitous examples include doctors advising patients to lower stress, modify diet, exercise, and take medications as prescribed. Yet, for example, in the case of a patient with diabetes, we don't refer to diabetic ketoacidosis treatment as behavioral health treatment, though the patient's behavior no doubt contributes to this condition. And we certainly would never call the ICU or stepdown unit the "behavioral health unit," even though adequate holistic treatment in these settings includes counseling the patient with diabetes on changing his/her behaviors that led to the ketoacidosis. Just as in diabetes, the underlying basis of psychiatric illness is biologic processes gone awry. First and foremost, a psychiatric medical illness requires complicated and often precarious medications to treat. As in other medical specialties, modifying behavior does not treat the illness, but merely serves to help transmute the course.

In sum, I wholly agree with Dr. Nasrallah's eloquent assessment regarding the problems with the title behavioral health in lieu of psychiatry. I also might have taken the discussion a step a further: Because psychiatric illness affects every aspect of a person's life—such as work, social, and personal—it requires a terminology commensurate with the medical gravity it warrants. So in addition to not referring to the specialty as behavioral health, I have wondered if the name psychiatry could be replaced with a more medical-sounding term such as "cerebrology" or something of the sort. But one step at time.

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The evolution within our field of the use of "behavioral health" has disturbed me to the same extent it has for Dr. Nasrallah. I founded and direct a psychiatric treatment facility in Florida. We are a teaching facility affiliated with 3 psychiatric residencies, 8 medical schools, and 60 physician assistant (PA) schools. In all of the literature (eg, evaluations) from the PA schools, they refer to their rotation with my program as "behavioral health." I have been attempting to correct them for years! I teach all residents and students to correctly use the terms "psychiatry" and "psychiatric." I understand there may be stigma associated with the latter terms, but the field reinforces that stigma by avoiding the use of these terms.

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Pre-authorization and 'hold harmless' clauses

Regarding Dr. Nasrallah's editorial "Pre-authorization is illegal, unethical, and adversely disrupts patient care" (From the Editor, Current Psychiatry. April 2020, p. 5,10-11), I am so glad he wrote about this egregious, illegal, unethical, and grossly disruptive practice. I would like to suggest an angle to our organized response to this trend based on my experience as a member on the Committee on Managed Care of the American Psychiatric Association

from 1991 through 1993 as a Burroughs Wellcome Fellow. The chair of the Committee and President and CEO of Sheppard Pratt Health System at the time, Steve Sharfstein, MD, MPA, underscored the importance of not signing a "hold harmless" clause on any contract whatsoever.

Recently to my surprise, while navigating a pre-authorization request for a young patient with bipolar disorder who had accepted the inclusion of lurasidone in his treatment regimen while hospitalized, I found that the CoverMyMeds Business Associate Agreement is required for a user to accomplish pre-authorization online. Having a little extra time for due diligence that day, I read this lengthy agreement carefully. The CoverMyMeds user agreement purports not to offer "medical advice, does not determine medical necessity, insurance coverage or copays and does not otherwise engage in the practice of medicine" (see www.covermymeds.com/main/about/privacy/tos/). Interestingly, the agreement goes on to purport that the whole process is for informational purposes only, not a substitute for clinicians, professional medical judgment, or for individual patient assessments and examinations. Of course, another factor is that the information provided by the process is "solely at the user's and health care provider's own risk." Finally, the agreement requires the user to agree to "indemnify, defend, and hold harmless CoverMyMeds and its affiliates … from any demands, claims, damages, liabilities, expenses, or harms (including attorneys' fees) arising out of or related to your use of our Services or breach of these Terms of Service."

Throughout my 25 years of solo private practice, I have refused to sign hold harmless clauses and I refused to sign the CoverMyMeds user agreement. I have made it my practice never to obtain pre-authorization unless the patient is with me in the room during an appointment because the process of navigating pre-authorization does become part of the treatment, however unfortunately. As an alternative, for my patient with bipolar disorder, I was able to use a phone number to talk to a representative of the pharmacy benefit plan that was contracted with CoverMyMeds. Without signing on to be a Business Associate, we accomplished the goal of continuing with the medication as recommended and implemented for 2 preceding months (often pre-authorization actually means continuing authorization, doesn't it?). I believe if all psychiatrists were to adopt this kind of stance, we could make a change. I know there are anti-trust considerations involved in fee negotiations, but when it comes to the egregious practices of managed care, pre-authorization, and hold harmless clauses, it seems to me that we can mount a counteroffensive to great effect.

Further, I want to stand in strong support of Dr. Nasrallah's editorial "Stop calling it 'behavioral health': Psychiatry is much more." When I began my first job post-fellowship, I was alarmed to find that our outpatient offices had been named a "counseling center." Due to such misleading, stigmatizing characterizations, as Dr. Nasrallah pointed out, we have only slid further down the slope into the realm of "providers of behavioral health services." As an old hand working psychiatric locum tenens told me, we psychiatrists had long since missed the chance to "band together like musk oxen" to defend our profession.

However, I believe it is not too late. With the strength of Dr. Nasrallah's leadership and a more overt, collective stubbornness coupled with an undying commitment to excellence, we can and must push hard against the insurance and hospital entities, which continue to profiteer from the practice of medicine without a license—using the tools of hold harmless clauses, anti-trust laws in their favor, and misinformation about the scope and efficacy of practicing psychiatry per se. The challenge is to figure out exactly how to proceed.

Although some manage to thrive in independent practice, collectively our struggle seems considerable, but not insurmountable.

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