

MENTAL HEALTH SERVICES

**On Family-Oriented
Collaboration Between Medical
and Mental Health Professionals:
An Interview With Donald A.
Bloch, MD
Pg. PS 1, 2**

**Shared Decisionmaking in Mental
Health Care
Pg. PS 2
By Steve Miccio**

**On Quality Healthcare
Pg. PS 2**

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**On Family-Oriented Collaboration Between Medical and Mental Health
Professionals: An Interview With Donald A. Bloch, MD**

Given the well-established connections between mind and body, efforts promoting a new model of care should not be surprising. Some advocates of such a change want to replace the medical model of care with a biopsychosocial model of care. This would integrate, rather than isolate, issues of mind and body and include family as a principal focus. One organization promoting this model, the Collaborative Family Healthcare Association (CFHA), also advocates for a redesign of our healthcare delivery system to one which makes it easier for medical and mental health professionals to communicate and collaborate. To find out more about this effort, why it is important, and how it might best be achieved, we spoke with Donald Bloch, MD – a practicing psychiatrist, one of CFHA’s founders and, for 13 years, editor of its publication, *Family Systems Medicine*, now an APA publication, renamed *Families Systems & Health*.

REVIEW: Why should primary care and mental health practitioners collaborate?

DR. BLOCH: Essentially any patient brings in a mix of psychosocial and biological issues to a healthcare situation. In many instances, one or the other of those predominates, but both dimensions are always operative. Without recognizing and addressing both, care and recovery are hampered. Additionally, the contributions of the family to creating the problem and assisting in the solution are lost. In one study, when we looked at random accidents, we found that psychosocial issues were evidenced in one of two ways – either as causative or reactive factors. It was very hard to exclude psychosocial contributions – so it’s always both. And that influences everything from how people define, and families respond to, their own conditions and more. So one of the reasons for collaboration is to bring both perspectives into play when needed.

REVIEW: Ideally speaking, what would collaboration look like?

DR. BLOCH: It might not be needed all the time, but if a family therapist has his or her office in the same suite down the hall, the physician can say ‘let me introduce you to Dr. ‘so-and-so’ and you can, in effect, easily have somebody listen with another set of ears. I have a colleague in my practice who just said, ‘I see this woman who has funny hallucinations and I don’t know what to make of them.’ So we set up a meeting for the three of us and, even though I do not directly contribute to her physical care, I can hear with another set of ears, family ears or psychosocial ears, if you will. So it allows for a different kind of intervention.

REVIEW: What should the healthcare system look like for this ideal to exist?

DR. BLOCH: It would be as seamless as possible. On site collaboration would be best. If you have to refer somebody elsewhere, it is more disruptive for everyone. Patients sometimes feel like they are being rejected or blamed. But if you can simply say, ‘here’s so-and-so, let’s ask him or her to sit in with us,’ it doesn’t have the disruptive effect that even the primary caregiver might suffer from. *On site and seamless* is by far the easiest, least expensive and best way to do that. Different locations and referrals can be hazardous in that they can negatively affect how people perceive the situation.

REVIEW: How does our current system compare to the ideal?

DR. BLOCH: Dreadfully! It’s highly dysfunctional...in many ways. The worst is it is so procedure based that reimbursement of patient care doesn’t reflect a measure of care, but rather the number of procedures. In the old days, when doctors couldn’t really do anything, they’d come to the house, give you analgesics and a few hot compresses but they would come and the family would be a part of the whole dynamics instead of isolating patient from family and the influences of family. These days, home visits are too expensive but in many ways, the system unnecessarily favors division and the lack of a human dimension to the work. I think chopping things up more and more has a bad effect on the practitioners as well. It gets to be how they see their own lives. This may be far afield, but it’s true. It’s a subtle price – they may not even be aware of it. I think it means the aspirations they might have had for patient care and what they want to do with their professional and personal lives are almost taken away from them. And if you see why people leave medicine, for example, they become experts in a procedure and all they do is that procedure and they’re bored out of their minds.

See **Bloch** on Pg. PS 2

Bloch, continued from pg. PS 1

REVIEW: Are you saying that they lose the sense of really helping their patients?

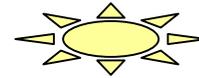
DR. BLOCH: That's right. They never see the whole person in the human context. Geriatrics is a good example. There is a lot of biology there but also a lot of psychosocial care. Family is always deeply involved. We can't ignore it. And shouldn't.

REVIEW: Given our less than ideal system, what steps can practitioners take to collaborate with each other?

DR. BLOCH: What I'd really like to see them do is try to create group practices that are integrated. Offer a room in the practice for an MSW, a family psychiatrist of whom there are more and more lately, or some other mental health practitioner. Other than that, make the most out of referrals. One good rule is to have all stakeholders in the health situation involved in the treatment process, keeping lines of communication open between all – patient, physician, family, mental health professional, administrators, and so on.

REVIEW: What organizational resources are available to help practitioners build collaborative understandings and skills?

DR. BLOCH: The Collaborative Family Healthcare Association now sponsors regional conferences in the hope of reaching more people. Its web site has links to resources and its publication has useful articles. □



Shared Decisionmaking in Mental Healthcare

By Steve Miccio

For many reasons, establishing shared decisionmaking partnerships is still a struggle. One reason is that, in mental health, fears of failed decisions prevail. Those fears may be based on concern for public safety, concern for patient and family or just simply the human paternal instinct to protect all from harm. Yet shared decisionmaking based on discussions of, and plans for, success and failure can actually reduce such fears by preparing both parties for the unexpected or untoward. Consider the following scenarios of patients who want to discontinue or reduce their medications.

No Shared Decisionmaking: Patients discontinue or reduce their medications without telling their therapists. This may not only adversely affect patients' conditions – possibly to the point of requiring hospitalization – but may also erase any trust, or prevent the building of trust, between patients and therapists. In fact, as noted in a New York State Office of Mental Health White Paper (2004),¹ with guidelines for care that were developed and validated by thousands of mental health patients in NY, patients typically don't trust their therapists. They see the mental health system as being grounded in punishment and report not telling their therapists how they truly feel in fear of either having their medication increased or being hospitalized.

Shared Decisionmaking: The patients tell their therapists how the medications make them feel as well as any negative beliefs they may have about the affect of those medications on their overall health. The therapists, in turn, would empathize with their patients and discuss options that may include the following: possible effects of eliminating or reducing medications; alternatives to medications or ways to address side effects; and a plan for recovery.

Steps that therapists can take to establish sound relationships and shared-decisionmaking partnerships with their patients include: getting to know and treating the whole person, not just the symptom(s) or diagnosis; listening actively; building treatment plans that include patients' views of what recovery means; developing plans to address crises, treatment failures and successes; and instilling the hope of recovery from the very beginning.² Fear of failure of partnered plans can be eased by learning about risk management and liability.

Shared decisionmaking can challenge one's values and beliefs in mental illness. Developing a trusting relationship that goes beyond symptom management is also challenging. However, if therapists promote recovery-based services as opposed to illness-based services, the outcomes will be more quality of life driven and help to prove that recovery is possible for everyone. □

¹ Visit www.projectstoempower.org.

² See note 1 and click on 'White Paper' for more details.

On Quality Healthcare

Appendix 4 of the New York State Office of Mental Health (NYSOMH) 2005-2009 Statewide Comprehensive Plan for Mental Health Services, otherwise known as the "White Paper", identifies ten rules for quality mental health services.¹

- There Must Be Informed Choice
- It Must Be Recovery Focused
- It Must Be Person-Centered
- Do No Harm
- There Must Be Free Access to Records
- It Must Be a System Based On Trust
- It Must Have a Focus On Cultural Values
- It Must Be Knowledge Based
- It Must Be Based on A Partnership Between Consumer And Provider
- There Must Be Access to Services Regardless Of Ability to Pay.

These rules, which reflect the collective voice of several thousand patients throughout NYS, were taken seriously enough to have been included in the NYSOMH's plan – with the stated intent of infusing recovery-based principles into evidence-based practice. It seems clear, then, that the NYSOMH has accepted the premise that clinical expertise, while essential to quality mental healthcare, is not, by itself, sufficient for its achievement.

Additionally, you might note that these rules are just as applicable (and, for the most part, have been applied) to all legally competent medical patients. As decades of studies have shown, the way healthcare is provided can have an effect on the outcomes of care – promoting improved outcomes when patients are able to engage in their care in the ways outlined by these rules. What we're really talking about, then, is not just quality mental health-care, but quality healthcare for all patients. □

¹ <http://www.omh.state.ny.us/omhweb/statewideplan/2005/appendix4.htm>.