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Collaboration-Oriented Approaches to Help in Mental Health Care

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> Abstract • I emphasize the relevance of Šugman Bohinc's target article not only for the development of collaborative social work (CSW), but also for the enrichment of the biopsychosocial approach in mental health care through collaboration-oriented approaches to help. Her transtheoretical, interdisciplinary and transdisciplinary conceptual framework is needed for the radical change of the predominant biomedical approach, which, according to growing evidence, increases pathologization, medicalization, medicamentalization, institutionalization and stigmatization. On the epistemological level, her postmodernist, constructivist and social-constructionist perspective points to what the biomedical approach needs most: the deconstruction of the usual objectivistic understanding of mental health and the construction of the epistemologically more inclusive, contextualized and integrated descriptions of mental-health phenomena. However, at the end there is a question: what are the reasons for the difficulties in the implementation of the collaboration-oriented approaches to help, as the situation in the field of social and health care in Slovenia is deteriorating dramatically?

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« 1 » In her target article, Šugman Bohinc has convincingly outlined a philosophical and conceptual framework for CSW practice. As her conceptual framework is transtheoretical and transdisciplinary, it is (also) relevant and valuable for all professionals in the field of mental health. As I work in this field as a psychotherapist and psychiatrist (Možina 2024), I will therefore limit my commentary to the applicability of her framework to mental health care.

« 2 » The "collaboration" concept is used with different meanings and contents in several models of primary care-based mental health treatment, including:

- Screening, Brief Intervention and Referral to Treatment (SBIRT) (Babor, Del Boca & Bray 2017),
- the Collaborative Chronic Care Model for mental health conditions (CCM) (Bauer et al. 2019),
- the Primary Care Behavioral Health (PCBH) Model (Reiter, Dobmeyer & Hunter 2018),
- the Co-location of Services Model (Lalani & Marshall 2022), and
- the Collaborative Care model (CoCM) (Reist et al. 2022).

For example, CoCM is an evidence-based way to improve patient outcomes, team collaboration, and provider satisfaction in primary care settings, with randomized controlled trials supporting its efficacy across multiple psychiatric conditions (Huffman et al. 2014). It focuses resources on an identified patient population suffering from mental-health concerns, utilizes an integrated care manager with mental-health training, and incorporates decision-support and case review by a psychiatrist. CoCM relies on algorithmic, stepped care with systematic follow-up and monitoring of patients.

« 3 » The Canadian Collaborative Mental Health Initiative has defined "collaborative mental health care" (hereafter CMHC) as an effort to improve the mental health and well-being of people "by enhancing the relationships and improving collaboration among health care providers, consumers, families and caregivers; and improving consumer access to prevention, health promotion, treatment/ intervention and rehabilitation services in a primary health care setting" (Gagné 2005: 1). The CMCH contains four key elements: accessibility, collaborative structures, richness of collaboration and consumer centeredness (ibid: 4).

« 4 » The most valuable aspect of Šugman Bohinc's contribution is the philosophical-epistemological justification of collaboration-oriented approaches to help, which is in line with the tradition and development of the biopsychosocial approach and which is not addressed by any of the above-mentioned models.

Biomedical Approach	Biopsychosocial collaboration-oriented approaches to help
medical explanatory model and its expert (and hierarchical) discourse, including its pathology focus, and binary-logic focus ("right" or "wrong") (§29)	relational, dialogic-narrative, transformative (§19);
objectivity (§8), common sense, realism (§9), certainty (§30)	irony, anti-realism (§9), relativism, uncertainty (§12), linguistic and dialogical turn (§24)
objective knowledge, observation without observer, experience without experiencer (§11)	participant observer, epoché, phenomenological reduction (§11), reflective practitioner (§19)
imposition of pre-modern and modern Western civilization concepts of reason, truth, and reality on non-Western cultures through power expressed in terms of domination, subjugation, exploitation and coercion (§9)	recognition, respect and valuing diversity (§24)
Western diagnostic categories of mental disorders are exported and adopted globally, often displacing national, indigenous, and local ways of helping people in distress (§9)	empower individuals to rewrite and reauthor their personal, familial, or collective narratives by exploring the sociocultural and individual origins of their psychosocial problems (§13)
Modern disciplinary power systems produce "reality" and "truth" (§10)	analysis of power dynamics in the process of help (§10)
knowledge as a form of power (§10)	deconstruction of power (§24), knowledge as socially constructed and participatory (§19)
epistemic injustice; knowledge of the expert is privileged over that of the non-expert (the client) and is considered more objective, reliable, and valuable (§10)	epistemic equality: utilization of the client's theory of change (§10)
focus mostly on the individual factors of psychosocial problems (§13); attribution of responsibility for the problems and their solutions to the individual (§13)	sociocultural influences as possible sources of human distress (§13)
individual (§19)	person-in-relationship (§19)
individual self as a "state of nature" (§19)	individual as a "state of language" (§19)
fixed and essential identities (gender, ability, ethnicity, mental health) (§24)	deconstruction of fixed identities (§13)
neurobiology (§28)	interpersonal neurobiology (§28)
objective third-person perspective (§28)	second-person perspective (§28)
the brain is the cause of almost all positive change in a client (§29)	sensitivity to the role that various social and cultural factors play in the development of psychosocial problems (§29)
hard science (§29)	merging of soft and hard sciences, integration of scientific and experiential perspectives, neurophenomenology (§29), complexity science (§30)
movement of individual dancers (§17)	dance (§17)
singular entities (§17)	conjunctions, co-action (§17)

Table 1 • Šugman Bohinc's epistemological differences between the biomedical approach and biopsychosocial collaboration-oriented approaches to help.

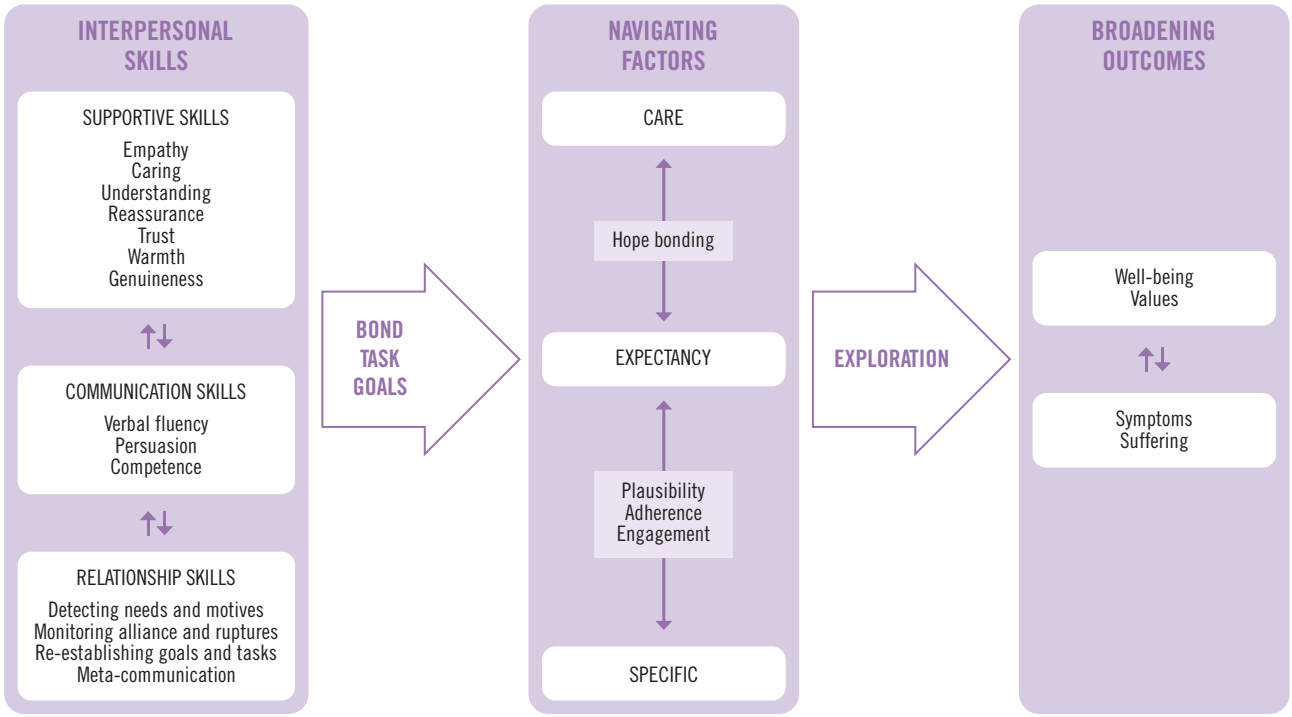

Figure 1 • The transdiagnostic, transtheoretical, transdisciplinary and transcultural CARE-Model for treatments of mental and physical health problems (Flückiger et al. 2024: 8)

Thus, one of the major problems in the field of mental health, the dominance of a biomedical approach based on an objectivist epistemology, is not addressed, while Šugman Bohinc defines the collaborative biopsychosocial approach on the basis of postmodernism, constructivism and social constructionism. The differences between the two approaches that she emphasizes are summarized in Table 1. While both social work and psychotherapy have absorbed postmodern ideas, this is not the case for mainstream psychiatry.

« 5 » There is growing evidence that the relatively poor outcomes of classical psychiatric treatment are related to an inappropriate biomedical model that increases pathologization, medicalization, medicamentalization, institutionalization and stigmatization (Moncrieff 2008; Bentall 2009; Davies 2013; Gøtzsche 2015; Shorter 2021). The biomedical model defines health as the absence of disease, and seeks the origin of disease in the body, so that in the case of mental disorders, it is primarily a disorder of biochemical and/or neurophysiological processes in the brain. Diagnosis is based on a specific identification of this bodily cause and is the basis for planning and implementing a specific form of therapy, which is effective in many cases of physical illness (e.g., appendicitis followed by surgical removal), but not in cases of mental disorders and illnesses, because psychosocial factors are not taken into account. The biomedical approach has led to (sub)specialization in the organization of service provision, leading on the one hand to excessive fragmentation and on the other hand to an excessive standardization of treatment procedures, where the "golden goal of medicine" of one treatment being appropriate for all patients, regardless of context, is attempted to be fulfilled. Treatment is focused on the individual or on a single organ, to the exclusion of the patient's close and wider social networks (Možina 2002).

« 6 » The biopsychosocial approach has evolved from broader cultural currents, traditional healing practices and humanism. It emphasizes holism over mind-body dualism, defining health as a state of physical, mental and social balance. It explains both health and illness as the result of an interplay of biopsychosocial factors in a multicausal manner. Instead of categorical psychiatric diagnosis, which by scientific and professional criteria is useless for treatment and even harmful, as it contributes to excessive pathologization, medicalization and stigmatization, it develops means of assessment and diagnosis that take into account the individual in their social and cultural context. It seeks to integrate subspecialized and fragmented forms of treatment, and to tailor the way in which treatment is provided to the needs and characteristics of each individual patient and their particular social environment (Možina 2021, 2024a).

« 7 » As Šugman Bohinc has pointed out, the study of effective CSW practices

draws heavily on psychotherapy research, e.g., on common factors and contextual models (Cameron & Keenan 2010). Recently, Bruce Wampold and Christoph Flückiger (2023) proposed an extension of the contextual model, the CARE-model, as an evidence-based transdiagnostic, transtheoretical as well as transcultural model with three pathways to the benefit of all mental health (as well as physical health) treatments: The CARE pathway (caring, attentive, real,[1] empathic), the EXPECTANCY pathway, and the SPECIFIC pathway (Figure 1). This model integrates the effects of relationship factors and specific ingredients, making it important for various domains, including social work, (clinical) psychology, special pedagogy, psychotherapy, psychiatry, and medicine. Although research and clinical attention have mostly focused on the alliance between a clinician and a patient in face-to-face interactions, there is preliminary evidence concerning the alliance between patients and other clinic staff, systems of care, or the program in Internet-mediated services.

« 8 » Based on extensive meta-analytic evidence for the contextual model and CARE-model, Flückiger et al. (2024: 1) propose four relevant implications for future training and practice in transdiagnostic and transtheoretical approaches to healthcare treatment:

- the development of a transtheoretical legal framework for mental-health treatments,
- the formulation of evidence-based transtheoretical interpersonal skills,
- an orientation toward transtheoretical therapeutic factors, and
- the exploration of comprehensive treatment outcomes.

« 9 » Although the dominance of the biomedical model is a global phenomenon, Slovenia is one of the countries where the orthodox psychiatric establishment maintains a more rigid version of it. For example, orthodox Slovenian psychiatrists and clinical psychologists insist on categorical diagnostics as the only possible starting point for successful treatment (Možina 2024a) and try to prevent psychotherapists from being integrated into the public health system in any way (Možina 2024b). As the WHO Expert Commission notes, this is followed by overprescription of psychotropic drugs and inpatient rather than community-based treatment, making deinstitutionalization in Slovenia much less effective and rapid than elsewhere.[2] So, I wonder: How is it that despite the scientifically sound advantages of the biopsychosocial collaborative approach, the biomedical approach prevails not only in Slovenia but throughout Europe and in most countries of the world? What are the reasons and obstacles that prevent the implementation of collaboration-oriented approaches to help in Slovenia? Q1

« 10 » Šugman Bohinc and the members of the team at the Faculty of Social Work, University of Ljubljana, are important actors in "the Slovenian story of self-organization and cooperation" (Možina 2020). This story tells how this team has been part of a network for decades, working for changes at micro, meso and macro levels of the e-system towards biopsychosocial collaborative approaches to help. This network is like David battling against biomedical Goliath. In the social-care system, this is reflected in the decline of CSWs in Slovenia and in the increasing bureaucratization of the network of national social-work centres, which are becoming increasingly inefficient, understaffed and repressive (also due to new legislation which has transferred the decision-making on repressive measures from the social-work centres to the courts, which are light years away from a collaborative approach). In addition, since 2010, the social inequalities in Slovenia are growing rapidly (Leskošek & Dragoš 2014; Dragoš 2016; Huber, Lipovec Čebron & Pistotnik 2020). In the healthcare system, Slovenia is experiencing "problems with financing, the inefficient management of public health institutions, absenteeism, a shortage of physicians, the number of people experiencing unacceptable waiting times, and above all, the uncontrolled flow of money that does not follow the patient."[3] In the mental health care system, the Slovenian psychiatric hospitals are the unshakeable fortresses of the biomedical approach and the community-based approaches are understaffed and underfunded (Kaurič, Stolc Jež & Širaj Mažgon 2012).

« 11 » According to the four criteria of the Canadian Collaborative Mental Health Initiative mentioned above, the situation in Slovenia is deteriorating dramatically: the accessibility of social and health services is decreasing (e.g., waiting times for psychotherapy services are one to five years), instead of collaborative structures and the richness of cooperation there is a growing fragmentation of services, and consumer-centredness is a nice aspiration that is becoming more and more distant. Is there a connection between the decline in collaboration-oriented approaches to help in Slovenia and the deterioration of key indicators of the quality of social and health care in Slovenia? Q2

« 12 » In Slovenia, we, mental health professionals, still have a long way to go in developing a biopsychosocial approach. A lot of open-mindedness, open-heartedness and courage will be needed to face the discomfort of uncertainty that inevitably comes with collaboration, as Jean Piaget (1995) also pointed out. We can never know where collaboration will lead to, because it involves equality between different personalities, autonomy, open dialogue, rationality, reciprocity, contradiction, policentrism, mutual confirmation, the need for proof, inventing the path while walking, heterostasis, distinguishing between "facts" and ideals, and accepting not knowing where collaboration will lead. This brings me to my final question: How could CSW be implemented in the Slovenian social care system and collaboration-oriented approaches to help in the Slovenian mental health care system? Q3

1| The concept "real" is meant in a very pragmatic sense and refers to the sincere, authentic personal relationship between therapist and client (Gelso 2011).

2| "Looking back, looking forward: Rapid assessment of the mental health system in Slovenia: Report of a virtual mission by the Regional Office for Europe," World Health Organization, September 2020, https://www.zadusevnozdravje.si/wp-content/uploads/2021/04/WHO-mission-report-on-mental-health-in-Slovenia-2020-1.pdf

3| "Overview of the situation in Slovenian healthcare," https://www.gov.si/en/news/2023-01-20-we-will-prepare-healthcare-for-all-challenges-that-lie-ahead

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