The “Joint Principles” statement (JP-BH) is a welcome contribution to the development of a new health care system for the 21st century. Because the Patient-Centered Medical Home (PCMH) is the cornerstone of efforts to revive primary care in the United States, a consensus statement emphasizing the centrality of behavioral health could not be more timely and important.

The American Association for Marriage and Family Therapy (AAMFT) represents a mental health profession with a long track record in integrated primary care, particularly with family medicine. We begin by affirming several core themes in the JP-BH. We then offer a systemic/relational perspective on the Patient-Centered Medical Home (PCMH) that goes beyond the focus of the JP-HP.

Our Areas of Agreement

We applaud the report’s assertion that a whole-person orientation is central to humane, effective, and cost-containing health care. Just as each individual is an integrated person, not a set of disconnected organ systems, medical care must be fully integrated with behavioral health care.

Similarly, we underscore the report’s emphasis on coordinated care that counteracts the pervasive fragmentation in the current health care system. The physical presence of behavioral health professionals in health care facilities is a key design element that makes optimal coordination possible. Marriage and family therapists have been pioneers in collaborative care for more than a generation, with research to support a reduction in health care utilization (Law & Crane, 2000) and an increase in cost-effectiveness (Morgan, Crane, Moore, & Eggett, 2013), particularly with the inclusion of family based care in medical contexts.

Finally, we appreciate how the JP-BH tackles the payment challenge that can best support professionals on the ground. Traditional mental health “carve outs” stifle integration, as do funding streams that do not value sharing of costs savings across the whole health care team. Integrating behavioral health requires an integrated payment system.

Applying a Relational/Systemic Lens to the Joint Principles Statement

As family therapists, we know something about the “home” metaphor in the Patient-Centered Medical Home. Home is not just a location; it is a system of interlocking relationships. As professionals with a distinctly systemic/relational perspective, we offer the following perspectives to advance the dialogue about the PCMH.

First, the individualist lens of the “Whole Person” can obscure the interconnected relational web that surrounds each patient, including family, peer networks, cultural, ethnic, and faith communities, and formal and informal affiliations in civil society. Although these factors are not invisible in the report, they are mostly treated as “contexts” for a provider team to consider in treating individuals. Instead, we view this web of micro- and macro- relation-
ships as constitutive of the whole person, not merely the person’s ecological context. What’s more, these relationships are no doubt stronger influences on the patient’s overall health than any team of professionals. Using an individual person approach (even one that recognizes context) is limited both scientifically and clinically. As marriage and family therapists, we know that the treatment of patients is best done in collaboration with intimate networks and larger community and cultural connections.

Second, a systemic/relational perspective can offset the “physician-centrism” of the JP-BH. Although the report emphasizes teamwork, the terms “personal physician” and “physician-directed medical practice” convey the traditional physician-led team model. We see no reason why the chief coordinator of some patients’ care cannot be another health professional. If a patient’s main challenge is nutritional issues or family stress, for example, the nutritionist or the family therapist might be the best one to lead that visit and coordinate care.

Third, a systems-relational perspective can mitigate a potential downside of the team-oriented PCMH, namely, that if the principal focus of collaboration is interprofessional, patients may end up being cared for paternalistically (albeit benevolently) by a smoothly functioning group of professionals who ignore people from the patient’s system who should also be involved. Patients could be even more one down in the PCMH unless the inherent power of the provider team is offset by the patient’s social network. It is no surprise that the patient, family, and community engagement dimension of the PCMH (often referred to as “consumer engagement”) is far less developed than the professional collaboration dimension (Nutting et al., 2009).

Conclusion

The JP-BH document is an important step forward. We believe that marriage and family therapists bring a crucial conceptual lens and set of relational skills that can help the Patient-Centered Medical Home fulfill its potential. We look forward to working with our colleagues in other professions in that work.

References


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