PRACTICAL PSYCHOPHARMACOLOGY

Going Beyond 'Doing the Meds'

Dr. Richard Gottlieb has experienced the worst of times and the best of times in collaborative practice.

Also known as the "split care model" or, less formally, "doing the meds," the approach encompasses a range of formal or informal arrangements in which a psychiatrist takes responsibility for the medication management of a patient while another health care professional conducts psychotherapy.

The worst, without question, was when he was moonlighting as a psychiatric resident at a public mental health agency and was handed a stack of prewritten scripts for medications and asked to sign his name.

When he explained that it would be inappropriate for him to order or renew medications for patients he had never evaluated, "it created an uproar," he recalled in an interview.

"We're just trying to save you time," he was told.

"I was expected to be a pill dispenser, really, literally signing a stamp of approval on someone else's judgment," he said in an interview.

Fast forward to 2010.

Dr. Gottlieb is founder, owner, and clinic manager of PsycHealth, a cooperative independent practice association (IPA) in Phoenix, where he conducts diagnostic interviews with patients that draw on his training both as a psychiatrist and a psychoanalysis-trained psychologist.

Although he sees some patients on an ongoing basis for psychoanalysis, he directs most to colleagues with counseling skills best suited for each patient's needs, whether that might be a child psychiatrist, neuropsychologist, or a master's level counselor adept in cognitive-behavioral therapy (CBT).

He maintains responsibility for the patients' medications and overall progress, but otherwise acts as a "casting director," matching patients to the "right people with the right personalities and the right skill sets"—predominantly within the IPA.

The group shares leased office space and secretarial services, but each professional operates an independent solo practice—with no strings attached.

If he feels that a patient would be best served by a clinician with a psychotherapeutic orientation not found within the IPA, Dr. Gottlieb said he has no qualms about referring outside the group.

The IPA designed by Dr. Gottlieb "tries to pull together the benefits" of other models, bridging a voluntary integration of skills and resources with the autonomy intrinsic to a fulfilling psychiatric practice, he said.

Controversial to its core, collaborative practice between psychiatrists and other mental health professionals appears to be on the rise, driven by economic pressures of managed care.

A recent study tracked psychiatric patient office visits between 1996 and 2005, documenting a 35% reduction in psychotherapy-dominant appointments, from 44.4% to 28.9% (Arch. Gen. Psychiatry 2008;65:952-70).

The number of psychiatrists who said they provided at least 30 minutes of psychotherapy during all patient visits declined to 10.8% in 2004-2005, from 19.1% in 1996.

(Psychotherapeutic visits were statistically more common among self-pay patients, white patients, older patients, and patients in the Northeast region of the United States.)

The numbers represented a sharper decline in psychotherapeutic visits to psychiatrists than was seen during the late 1980s and early 1990s, and likely reflect basic arithmetic in a managed care world, said several clinicians who were interviewed for this story. A 50-minute visit for psychotherapy cannot match the reimbursement for four medication management visits during the same hour.

> 'Personally, I enjoy this a lot more ... I love collaborating. It seems to be more honest to refer to people who are very skilled in what they do—more skilled in parts of this than I am.'

From their point of view, managed care systems would rather pay the lower reimbursement rates charged by non-MD mental health professionals for ongoing psychotherapy visits, reserving payments to psychiatrists for brief medication management visits that other therapists cannot provide.

In another development, psychiatry's rich history of psychoanalytic therapy seems to be giving way in academic training to "evidence-based" psychopharmacology and CBT, approaches that are easier to assess in randomized trials than the slow unfolding of the unconscious through talk therapy.

Other forms of psychotherapy, including CBT, supportive or solution-focused therapy, or family therapy, are practiced by many mental health professionals, from psychologists and master's-level social workers and marriage and family therapists.

The APA Commission on Psychotherapy by Psychiatrists has voiced concern that in residency programs, fewer senior psychiatrists and mentors model and emphasize psychotherapy, and a newly released study appears to back up that belief.

Among 249 psychiatric residents from 15 training programs in the United States, 28% felt that not enough time and resources were devoted to psychotherapy, and a third did not believe psychotherapy training was fully supported by "key" leaders in their departments (Acad. Psychiatry 2010;34:13-20).

"Changes in practice patterns are affected by socioeconomic forces, the insurance industry, and pharmaceutical companies, all of which conspire to create specialization," Dr. Gottlieb said.

Serving as a coordinator of care 'has tremendous therapeutic significance.'

DR. FRANKEL

Although he pursued doctoral-level psychoanalytic training, which he feels helps him understand the epistemology of belief systems that influence his patients' illnesses, "it's very hard to see that level of investment is going to pay off in the long-run in today's climate," he said.

Fewer and fewer psychiatrists are able to do it all, delving into complexities of their patients' lives and minds during weekly psychotherapy visits, then taking out the prescription pad to manage their meds. It's a reality with which many psychiatrists have made their peace, particularly when the setting is conducive to true collaboration.

One of the study's co-authors, Dr. Ramin Mojtabai, works in a system at Johns Hopkins University that fosters periodic psychopharmacology assessment meetings that include himself, the patient, and the therapist—often a social worker by training—"who spends a longer time with the patient, and brings unique insights about the symptoms and the function of the patient.

"The therapist and the prescribing psychiatrist have the same goals in working with the patient. We are informed of each other's work, and that's a major positive point," said Dr. Mojtabai of the Johns Hopkins Department of Psychiatry and Bloomberg School of Public Health.

After publication of the paper that he coauthored with Dr. Mark Olfson of Columbia University, New York, Dr. Majtabai said that he was approached by several psychiatrists who relayed to him that "even in a short, 15-minute visit, they feel that a lot of therapy work is accomplished.

"I agree with that," Dr. Olfson said, particularly when occasional evaluative conferences are held to consider whether the goals of therapy are being met, or adjustments should be made—either in the medication or dose, or in the psychotherapeutic approach being employed. In real life practice, the "teamwork" concept varies widely, from scheduled patient conferences to "no real integration by design," even when professionals share office space and patients, Dr. Mojtabai said.

The patchwork quilt of current collaborative practice models has never been systematically studied to see whether patients benefit, or even if money is saved in the long run when more than one practitioner provides care.

Well-designed studies could lead to best-practice models, he said.

"We don't know which groups of patients benefit from which settings," or how often psychiatrists should see a patient receiving psychotherapy elsewhere," Dr. Mojtabai said, adding that models of collaboration need to be studied as well.

At his Center for Collaborative Psychology & Psychiatry in Kentfield, Calif., Dr. Steven A. Frankel spends a great deal of time interacting with colleagues, a welcome change from the long hours he once spent conducting psychoanalytic therapy.

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DR. GOTTLIEB

These days, he's a self-designated Med-Psych Coordinating Physician, doing a careful evaluation of each new patient, ordering psychological and medical testing, deconstructing the problems underlying symptoms, and assigning therapy to carefully selected consulting professionals such as social workers, school counselors, family therapists, psychopharmacologists, or primary care physicians.

"Personally, I enjoy this a lot more," Dr. Frankel said in an interview. "I like working with other people. I love collaborating. It seems to be more honest to refer to people who are very skilled in what they do—more skilled in parts of this than I am."

Serving as a coordinator of care requires a deep understanding of the patient, the diagnosis, and the system, Dr. Frankel added. "It's a relationship that has tremendous therapeutic significance."

Dr. Frankel said that he is implementing the Collaborative Treatment Method into his practice, and intends to soon implement studies of its efficacy and practicality.

His hypothesis? The collaborative model will prove to be more cost effective than slap-dash arrangements implemented by managed care systems today, and more practical than the psychotherapy-driven psychiatric practices of the past.

"I think the patients will fare better, too," he said. ■

By Betsy Bates. Share your thoughts and suggestions at cpnews@elsevier.com.