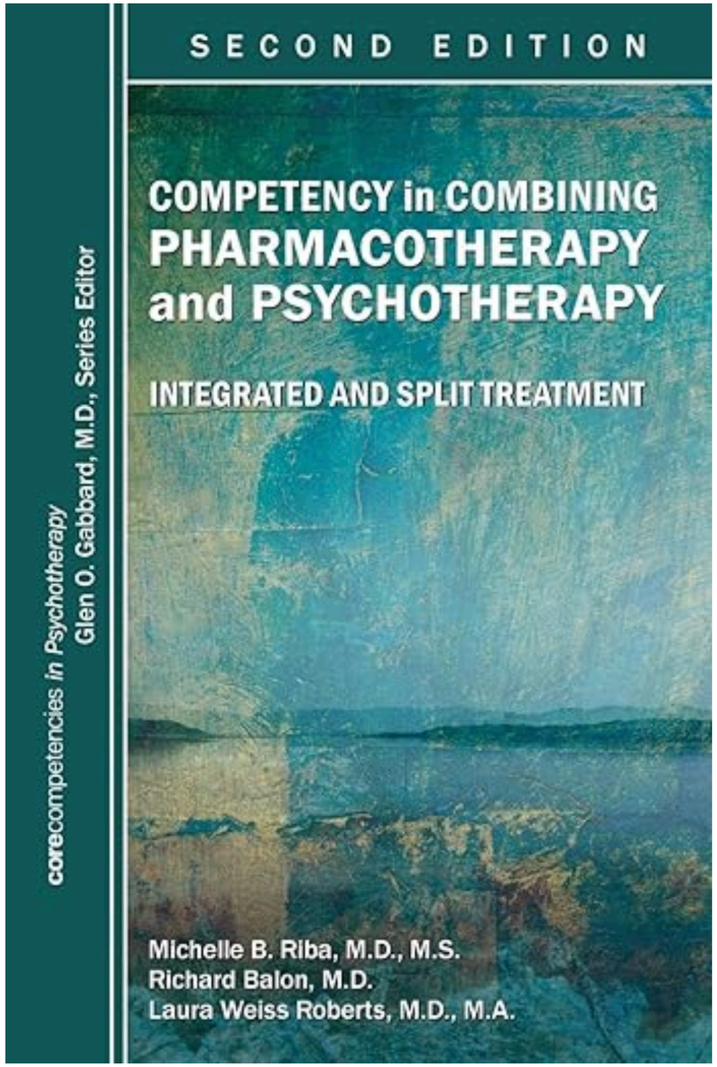
Coordination of Care in Split Treatment

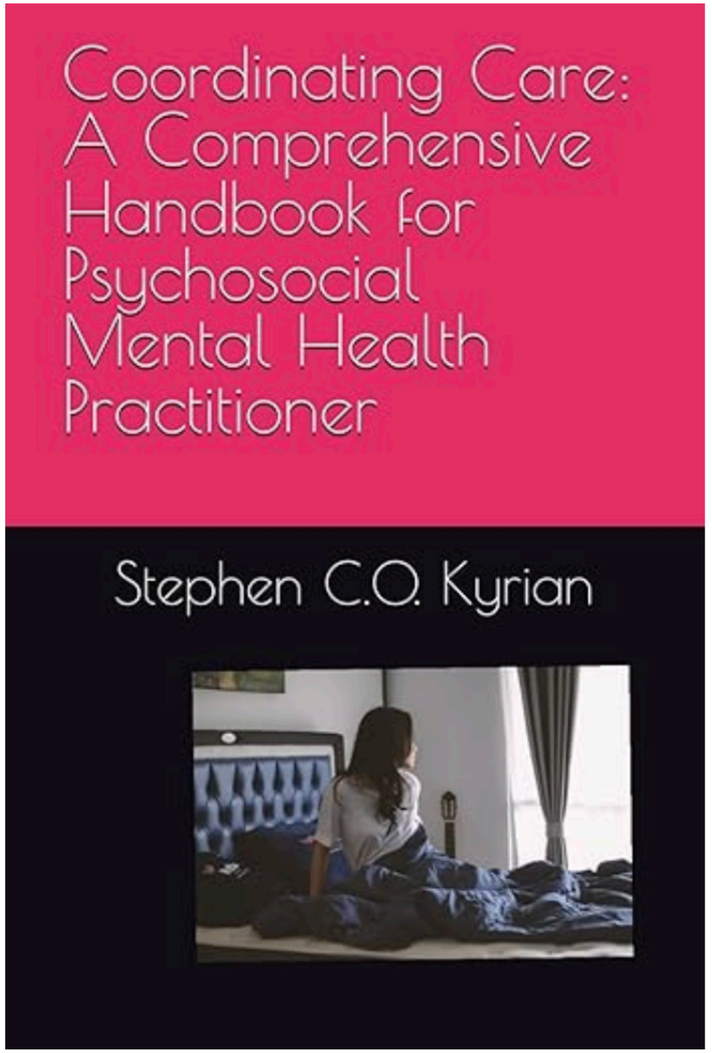
- Combined treatment (psychotherapy plus medications) is widely seen as the "gold standard" for most mental health issues. In general, patients in combined treatment experience superior treatment outcomes and lower dropout rates [e.g. Cujipers et al, 2020].

- In the modern era, most patients in combined treatment are receiving "split" treatment (AKA "collaborative" treatment, "three-party" treatment) [Kalman et al., 2010].

- Since 1980, the American Psychiatric Association (APA) has published multiple practice guidelines which stress the importance of good communication between prescribers and therapists in the case of split treatment. In addition, I found about a dozen journal articles which present additional guidelines for coordination of care— or which discuss how best to navigate issues of transference, conflict, splitting, etc.

There are entire textbooks devoted to the subject of coordinating care:





But there are very few *observational* studies on coordination of care…

so, how often do psychiatrists and therapists actually talk to each other when they share a patient?

How often do therapists and psychiatrists talk to each other about their shared patients?

Hansen-Grant and Riba (1995):

- Survey and chart review of psychiatric residents at University of Michigan (Ann Arbor).
- 26.8% of patients (77/287) were in split treatment.
- For patients who were in split treatment, the psychiatrist had spoken with the therapist at least once in…

53% of cases

(1x: 47.7%, 2x: 11.4%, 3-5x: 27.3%, >5x: 6.8%)

- Contact was more likely to occur when the therapist worked at the same clinic as the psychiatrist.
- Contact was initiated by the psychiatrist in 47.7% of cases, and by the therapist in 43.2% of cases.
- When contact took place, it was documented in the psychiatric chart only **8.4%** of the time.
- Written consent for contact was obtained only in **35.2%** of cases— in other cases, there was either “verbal consent” or no formal consent given.

How often do therapists and psychiatrists talk to each other about their shared patients?

Kalman et al (2012):

- Surveys were sent to 150 psychiatrists (61 responded). All psychiatrists were faculty members at New York Presbyterian (Manhattan) and Morristown Memorial (NJ).
- 41.25% of patients were in split care (785/1903).
- For patients who were in split treatment, the psychiatrist had spoken with the therapist at least once in…

76% of cases

- 18.2% of psychiatrists reported that they had spoken with the therapist at least once per quarter, for ALL of their split-care patients.
- First contact was initiated by the psychiatrist 51.7% of the time.

How often do therapists and psychiatrists talk to each other about their shared patients?

Avena and Kalman (2010):

- Survey of Manhattan psychotherapists.
- 36% of their patients (434/1197) were in split treatment.
- For patients in split treatment, the psychiatrist and therapist had spoken at least once in…

78% of cases

- 13.2% of therapists reported that they coordinated at least once per quarter for ALL patients in split treatment.

How often do therapists and psychiatrists talk to each other about their shared patients?

Baruch et al [2015] were the first to survey *patients* about their experience in split treatment.

In a survey of 502 patients in split treatment…

20% reported there was no communication between providers
28% reported that communication between providers took place “once or twice”
20% reported that communication between providers took place more than twice
32% did not know

59% said their therapist had requested ROI
25% said their therapist had not requested ROI
16% could not recall whether this had been done

53.6% said their prescriber had requested ROI
30.5% said their prescriber had not requested ROI
16.9% could not recall whether this had been done

Patient reported **increased satisfaction with overall treatment** when they felt that the two providers were working together.

What do the “practice guidelines” say?

A look at some published guidelines… (Part One)

“…it is difficult to specify precisely what an optimum number and frequency of supervision, consultation, or collaboration contacts between a psychiatrist and a nonphysician therapist should be.”

“[The psychiatrist] must provide an amount of supervision, consultation, or collaboration sufficient to assure that their ethical, medical, and legal responsibilities towards the patient are met and are consistent with any local or state guidelines outlining these responsibilities.”

- American Psychiatric Association

(Oh well, let’s take a look at some other guidelines…)

A look at some published guidelines… (Part Two)

Guidelines proposed by Hansen-Grant and Riba (1995):

- Establish communication between clinicians before the patient's first appointment— or, if this is not possible, "the referring clinician should at least send a written summary of the patient's treatment to date".
- Create a "treatment contract" delegating responsibilities to each provider (e.g. emergency coverage, need for monitoring). "Responsibilities should be clearly specified rather than implied", "preferably in a written agreement".
- "Clinicians should have regular contact every 1-3 months to discuss the patient's progress", "more frequently in certain cases".
- "Patient's treatment plan should bear the signatures of both clinicians".
- "All contact between the two clinicians should be documented by each clinician in a separate progress note".

Simplified Guidelines: A Modest Proposal

1. Routinely obtain consent for communication at the beginning of split treatment— even if you're not sure whether you will need it.

   It's best if this is treated as a standard part of patient "onboarding", along with the usual forms (such as HIPAA consent forms, etc). If you wait until the patient is in a crisis before requesting an ROI, you are more likely to run into problems.

2. At the beginning of split treatment, send a brief introductory note to your co-treater.

   E.g.: "Hello, I am a therapist who has been working with our mutual patient, T. S. TS has signed an ROI allowing us to coordinate care (attached). Please feel free to contact me at XXX-XXXX if you ever wish to discuss their case. I am generally easiest to reach between 3-4PM."

   In cases where you feel prompt contact is needed, say so!

3. If contact does take place, document it (even if briefly).

4. Ask a few questions about the patient's experience with their other provider.

5. When deciding frequency of contact, consider the following factors…

Consider more frequent communication when…

- The patient is not doing well.
- You're not sure whether the patient is doing well. [E.g. patient appears guarded, reserved, or disengaged, or is thought to be a poor self-reporter of symptoms].
- Patient is high-risk (or you suspect that there has been an increase in risk level).
- Patient is dissatisfied with one (or both) of their treatment experiences.
- You suspect that the other provider might be missing important information.
- You are seeking clarification and/or reinforcement of patient's treatment goals.
- (For therapists): You are worried about overmedication and/or excessive use of controlled substances.

Questions for discussion…

In practice, how often do you coordinate care with prescribers? How often do you think we should coordinate care (less often, more often, or about the same amount?)

What are your experiences coordinating with prescribers (good and bad)?

When you don't coordinate, what are some of the reasons?

What are your thoughts on psychiatrists who assume the role of "co-therapist"? (In other words, psychiatrists who are performing substantial amounts of psychotherapy with your clients, in parallel with your own treatment).

Has a patient ever refused to allow coordination of care? If so, what were the patient's reasons? How did you resolve the issue?

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