# Collaboration between prescribing physicians and psychotherapists in mental health care

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## INTRODUCTION

Patients treated with medication and psychotherapy for a psychiatric disorder may be treated by a single clinician, typically a psychiatrist, or by two clinicians, one prescribing medication and the other providing psychotherapy. Provision of the two modalities by two clinicians is often referred to as “split” treatment, while provision by one clinician is described as “integrated” care.

The prevalence of split mental health care appears to have risen in recent decades. Potential hazards of split treatment can occur when psychotherapy and pharmacotherapy are not well coordinated. They can be avoided if the prescribing physician and the psychotherapist proactively communicate with one another and establish procedures to support an effective collaboration. There are no data from clinical trials comparing the quality or outcomes of care between split versus integrated treatment.

Provision of a patient’s care by two or more clinicians is not unique to mental health care. Care is typically split between primary care and other medical specialists, as well as between physicians and nonmedical clinicians such as physical therapists. This topic emphasizes issues encountered in providing mental health care.

This topic describes challenges associated with split treatment, and describes approaches to collaboration under this model of care. Other features of the clinician-patient relationship in mental health care are discussed separately. (See "Overview of the therapeutic relationship in

psychiatric practice" and "The clinician-patient relationship in the era of information transparency".)

## CHARACTERISTICS OF SPLIT CARE

Split mental health care occurs when a patient receives two or more modalities of treatment from two or more clinicians. Split treatment is most commonly delivered by a:

- **Prescribing physician** – The psychiatrist or other physician (often in primary care) who prescribes medication for the patient's psychiatric disorder. In some jurisdictions, clinicians other than physicians might be prescribing medications (eg, nurses).
- **Psychotherapist** – Clinical psychologist, social worker or other mental health professional, or (more rarely) another psychiatrist who provides psychotherapy.

Split treatment has become increasingly common in our experience and supported by limited research. In surveys conducted by the American Psychiatric Association, psychiatrists reported that their patients were additionally treated by a second mental health professional in approximately 5 to 10 percent of cases in the 1980s, 30 to 40 percent in the 1990s [1,2]. In a 2010 survey of psychiatrists, limited by a low response rate, two thirds of respondents' patients received both medication and psychotherapy, about half from one clinician (the responding psychiatrist) and half in split treatment with the psychiatrist and another clinician [3].

## RATIONALE FOR SPLIT CARE

The trend from integrated toward split mental health care has been seen in the United States and other countries, driven by multiple factors:

- Payers seeking to lower costs of care.
- Financial incentives for psychiatrists (and their employers) favoring the practice of pharmacotherapy over psychotherapy.
- Low rates of psychiatrists per capita in many parts of the United States and other countries.
- A decline in the proportion of time in psychiatry training programs spent learning psychotherapy relative to pharmacotherapy, leading to fewer psychiatrists trained to provide psychotherapy.

- Payer requirements in some jurisdictions that nonmedical psychotherapists treat patients under the supervision of a physician.

- Split treatment may also be adopted due to particular treatment considerations. As an example, a psychiatrist providing psychodynamic psychotherapy may prefer to concentrate primarily on the therapy (including the transference generated in that therapy) and leave the complex issue of making prescribing decisions to someone else.

Split treatment is typically contrasted with integrated treatment, where pharmacotherapy and psychotherapy are delivered by one clinician, generally a psychiatrist. Integrated treatment avoids the structural challenges to communication and coordination encountered by two clinicians providing care. A clinician who provides both medication and psychotherapy is better situated to understand and address the effects of each, positive and negative. However, there are no clinical trials or rigorous data analyses comparing the quality or outcomes between split and integrated mental health care.

## ORGANIZATIONAL FACTORS

Collaboration between the prescribing physician and therapist in split mental health care can be easier or more challenging across different organizational structures of care. Illustrative tiers along a continuum of arrangements are as follows:

**Shared team or setting** — The prescriber and therapist work at the same ambulatory clinic or single-site group practice. They typically share a number of patients and practice under a common set of expectations. They may be members of a clinical team that treats patients in tandem, participate in a common clinical meeting, and use a single administrative system to schedule and record the completion of encounters. They share a common medical record to document treatment.

**Shared organization** — The two clinicians practice at different locations and may never meet face to face. They both are employed by the same organization, such as a health plan or provider network, which integrates one or more aspects of the clinical care they provide. This may be an electronic medical record that allows them to read one another's progress notes, look up appointments and medications, and leave each other messages. Other components of their respective practices operate independently.

**Independent clinicians** — The prescriber and therapist work independently from each other. They may or may not share other patients or have worked together in the past. Coordinating

processes necessary for an effective collaboration between them will be the result of their own efforts.

**Models of collaborative care** — Specific models of collaboration have been applied to mental health care [4,5]. They are typically intended for organization-wide application after pilot testing on a smaller scale. In addition to formalizing coordinating processes, the models often involve additional personnel (eg, a care manager) and other resources (eg, clinical metrics and analysis). The collaborative care model is discussed in detail separately. (See "Unipolar depression in adult primary care patients and general medical illness: Evidence for the efficacy of initial treatments", section on 'Collaborative care'.)

## POTENTIAL HAZARDS

When mental health care is divided between a psychotherapist and a prescribing physician, a number of problems can occur. Concerns about poor communication and coordination between the prescribing physician and psychotherapist in split treatment adversely affecting the quality of care [6-16]. These potential hazards can for the most part be avoided through collaboration between the clinicians. These include:

- Gaps in communication and coordination in split treatment are suggested by studies:
  - A 2012 survey of 61 full-time private practice psychiatrists of (of 150 surveyed; response rate of 41 percent) reported seeing a total of 1903 “medication-only” patients, 41 percent of whom received psychotherapy from another mental health provider [6]. Among the patients receiving split treatment who were treated by the psychiatrist for six months or longer, no communication had occurred between the psychiatrist and therapist for 32 percent of patients. Quarterly communication occurred for only 18 percent of patients.
  - An online survey of 502 patients who received treatment from both a psychotherapist and psychopharmacologist (or other practitioner who prescribed psychotropic drugs) found [17]:
    - 20 percent reported that communication between clinicians had taken place more than twice
    - 28 percent reported one or two communications
    - 20 percent said that no communication had taken place
    - 32 percent did not know whether communication occurred

Patient report of communication between clinicians, compared with no communication, was associated with greater patient satisfaction and comfort with treatment. (See 'Approaches to collaboration' below.)

- **Differences in clinical presentation** – The patient may present differently to each clinician. As an example, a depressed patient may appear sadder, more tearful, and hopeless with one, and more positive, energetic, and motivated with the other. These differences could be transient or due to lapses of time between visits or other factors such as transference issues (feelings, attitudes, desires, or fantasies that one person displaces (eg, subconsciously projects) onto another person. In certain types of patients, eg, those with borderline personality disorder, "splitting" can occur, whereby the patient sees significant others in either ideally positive or intensely negative terms. When this occurs between the patient and two treating clinicians, the patient may present very differently to each [18,19]. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis", section on 'Interpersonal difficulties'.)

- **Treatment goals** – Differences in treatment goals may also lead to differences in a patient's clinical presentation at a visit for psychotherapy or pharmacotherapy; for example, the intent of psychotherapy maybe to uncover unpleasant feelings, while the goal of medication treatment may be to reduce them.

- **Medication changes** – The therapist may be unaware of recent changes in medication, leading them to mistakenly assume that changes in the patient's clinical status were due to changes in the patient's psychological coping mechanisms, relationships and/or external events.

- **Psychosocial changes** – The prescribing physician may be unaware of significant psychosocial changes and stressors in the patient's life and may mistakenly assume that their evolving clinical status was in response to recent medication changes or to the inadequacy of an ongoing medication regimen.

- **Risk status** – Unshared information is of greatest concern when one of the clinicians is unaware of changes in the patient's clinical status putting them at risk of harm, such as increasing suicidality, substance misuse or substance use disorder, or an adverse drug reaction that is not recognized as such.

- **Adherence** – A patient may regularly miss appointments with one clinician, while the other clinician may be unaware of those absences and what they might represent [20].

## APPROACHES TO COLLABORATION

What follows are issues that clinicians should consider when collaborating in a split treatment.

**Waiver of confidentiality** — Effective collaboration between clinicians in split care cannot occur without a waiver of confidentiality and free exchange of clinical information between clinicians. Health care privacy regulations in the United States allow a clinician or practice to release protected health information upon receiving a request for information from another clinician or practice. We believe that when feasible, clinicians should go beyond this minimal requirement and discuss the sharing of information with the patient before it occurs. Obtaining and documenting the patient's consent can prevent later disruptions of treatment.

Even after confidentiality has been waived, clinicians should exercise judgement in what personal information (especially from psychotherapy) is shared based on treatment relevance and clinical risk. As an example, certain promiscuous, impulsive, or illegal behaviors from the remote past may not need to be revealed to the other clinician unless this history influences the patient's current risk status. If the behaviors have recently recurred or changed in frequency or degree, then it is essential to share the information. This should be understood by the patient, and the patient should be notified if such information is going to be shared. Clinicians might ask themselves, "If I were the other treater in this collaboration, what is important for me to know or understand about the patient at this time?"

**Initial contact between clinicians** — It is important for each clinician participating in a split treatment to, at a minimum, have some sense of the other clinician and their treatment orientation or philosophy.

The psychotherapist needs to explain:

- The types of mental health problems and/or disorders they treat
- The type(s) of psychotherapy they provide
- How knowledgeable they are about psychotropic medication

The prescribing physician needs to explain:

- How knowledgeable they are about the type of psychotherapy the therapist is providing.
- How comfortable are they in prescribing psychotropic medication, in general and for this particular patient with this particular disorder? This is particularly important when the prescriber is a primary care physician, who in our experience can vary widely in knowledge of, experience and comfort with prescribing these medications.

What is most important is that the psychotherapist appreciates and understands the use of medication for the patient, and that the prescribing physician appreciates and understands the use of psychotherapeutic interventions.

The two clinicians under optimal circumstances would have an initial discussion to arrive at some common understanding of the patient. This should include diagnosis, goals of treatment including target symptoms for each modality, and sharing of information about the patient's current substance use, suicidality, or involvement in an abusive relationship. Furthermore, clinicians should agree on how they will manage nonadherence to either treatment.

**Monitoring safety** — Both clinicians need to pay ongoing attention to issues involving the patient's safety, including suicidality, homicidality, and the use of substances. Both prescribed substances (such as opiates, stimulants, and some sedating or anti-anxiety medications) and nonprescribed substances (such as alcohol, marijuana, and cocaine) can lead to dependence, morbidity, and worsening of mental disorders. (See "Substance use disorders: Clinical assessment".)

**Information sharing** — There needs to be an arrangement between clinicians to share information about the patient's clinical status and treatment [21-23]. Often the most optimal arrangement would be a formal one unless the practitioners are well-known to each other and see each other frequently. Agreement on the means and frequency of such exchanges is best established at the outset of treatment.

**Communication methods** — The rise of the internet has provided many new modes through which clinicians can collaborate. Despite these advances, nothing quite replaces face-to-face meetings, which seems the most useful if not the most efficient. Face-to-face meetings allow clinicians to more clearly convey a wider, more complex range of information through body language, tone of voice, posture, and appearance. Even if subsequent meetings occur electronically, an initial, face-to-face meeting between collaborating clinicians can give each a better view of the other. However, a face-to-face meeting is not essential for a successful collaboration.

There are many more recent, electronic means to collaborate, from telephone calls to video, e-mail, and a shared electronic medical record (EMR) [24]. Some EMRs allow a clinician to "tag" a clinical note to be sent automatically to other clinicians.

The clinician receiving information needs to acknowledge receiving it, and to respond as needed within a reasonable amount of time. In setting up a collaboration, it is important for clinicians to discuss the form(s) of their communications and expectations with respect to

response time. Another consideration of electronic communications is to ensure that they remain private and secure.

**Contact frequency** — The frequency of the contact between clinicians depends upon a number of factors [25,26]:

- At the beginning of collaboration and during acute phases of treatment, there should be regular contact (eg, weekly or biweekly).
- More frequent contact may be needed during a crisis (eg, weekly or even daily). This should be done by telephone so a free and immediate exchange of information and impressions can take place.
- When the patient's clinical status is stable and medications are taken at maintenance doses, clinical contact can be much less frequent (eg, every three to six months). Communication can occur through confidential e-mail.
- If the clinicians share a number of patients, it would be wise for them to set up a regularly scheduled time monthly or bimonthly to review and discuss them.

**Availability** — The clinicians should make it clear between themselves and communicate to the patient which of the two of them the patient should call in an emergency, during a crisis, or amid a medication change. In some patients, particularly those with personality disorders, these may be complicated issues that need to be discussed in psychotherapy.

Other questions that should be addressed when relevant:

- What expectations should the patient have of the clinicians to be available outside of appointment hours?
- What procedures should they follow at these times to communicate with one of them.

The clinicians should also establish a means of notification when one of them is on vacation or out of town, and discuss coverage during these periods.

**Shared knowledge** — The prescribing physician and the therapist will ideally have or achieve a shared understanding of the effectiveness and limitations of treatments for an individual patient.

As an example, the number of medication trials undertaken can sometimes become a matter of disagreement between clinicians [27,28]. Patients can be very sensitive to these disagreements.

The prescribing physician should in most circumstances undertake a careful and organized series of medication trials to treat distressing symptoms that do not respond to the initial medication. The therapist and patient should understand that once reasonable medication options have been tried the patient will be maintained on the medication and dose that led to the best results.

Clinical issues that arise may not have an established answer, but need to be resolved for each patient individually. As an example, a patient who is on the medication regimen found to be most effective for their experiences periods of symptom exacerbation every few months and calls one or both clinicians for help. The most effective clinical response is unlikely to be the result of which clinician is reached first (eg, medication and support from the prescribing physician or a psychotherapeutic intervention and support from the therapist). The clinicians would want to discuss and, with the patient, come to a common understanding of factors underlying these crises and the most effective clinical response, with a resulting agreement on which clinician would be contacted and under what circumstances.

**Treatment adherence** — All members of the treatment team need to work together to encourage adherence to treatment. As an example, when a patient misses visits in one treatment and not the other, the absences should be addressed as part of both treatments.

## SUMMARY

- **Characteristics of split care** – Split mental health care occurs when a patient receives two or more modalities of treatment from two or more clinicians. Split treatment is most commonly delivered by a prescribing physician and a psychotherapist. (See 'Characteristics of split care' above.)

- **Efficacy of split care** – There are no data from clinical trials comparing the quality or outcomes of care between split versus integrated treatment. (See 'Introduction' above.)

  The prevalence of split mental health care appears to have risen in recent decades. Limited study has found split treatment to be associated with significant gaps in communication and poor coordination between the prescribing physicians and psychotherapists treating the same patient. (See 'Characteristics of split care' above.)

- **Potential hazards** – Potential hazards of split treatment stem from inadequate communication between clinicians and insufficient sharing of information about the patient's clinical status and treatment. Clinicians may have differing perspectives on a shared patient due to the following factors:

- The patient may present differently to each clinician.
- "Splitting" of clinicians into "good" and "bad" may occur with certain types of patients (eg, those with borderline personality disorder).
- The therapist may be unaware of recent changes in medication, and the prescribing physician may be unaware of significant psychosocial changes and stressors in the patient's life.

Unshared information is of greatest concern when one of the clinicians is unaware of changes in the patient's clinical status putting them at risk of harm, such as increasing suicidality, substance misuse or substance use disorder, involvement in a severely abusive relationship or an adverse drug reaction that is not recognized as such. (See 'Potential hazards' above.)

- **Approaches to collaboration –** The prescribing physician and psychotherapist will optimally establish at the start of treatment a process for sharing information over the course of treatment that includes (see 'Approaches to collaboration' above):
  - The method and frequency of communication.
  - Agreement on who the patient should call during a crisis.
  - Sharing perceptions of the patient's clinical status and of the treatment the other clinician is providing.
  - The patient's waiver of confidentiality following discussion of the importance of the free exchange of clinical information between their clinicians.

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