CAMFT'S 53RD ANNUAL CONFERENCE

JUSTICE FOR ALL

CAMFT

Empowerment / Collaboration / Resiliency

Thursday, May 4, 2017

10:15 A.M.–12:15 P.M. 2 CE Hours HANDOUT 1 OF 2

TH1 "Harmonious Collaboration with a Psychiatrist"

Presented by Donna Ehlers, MD

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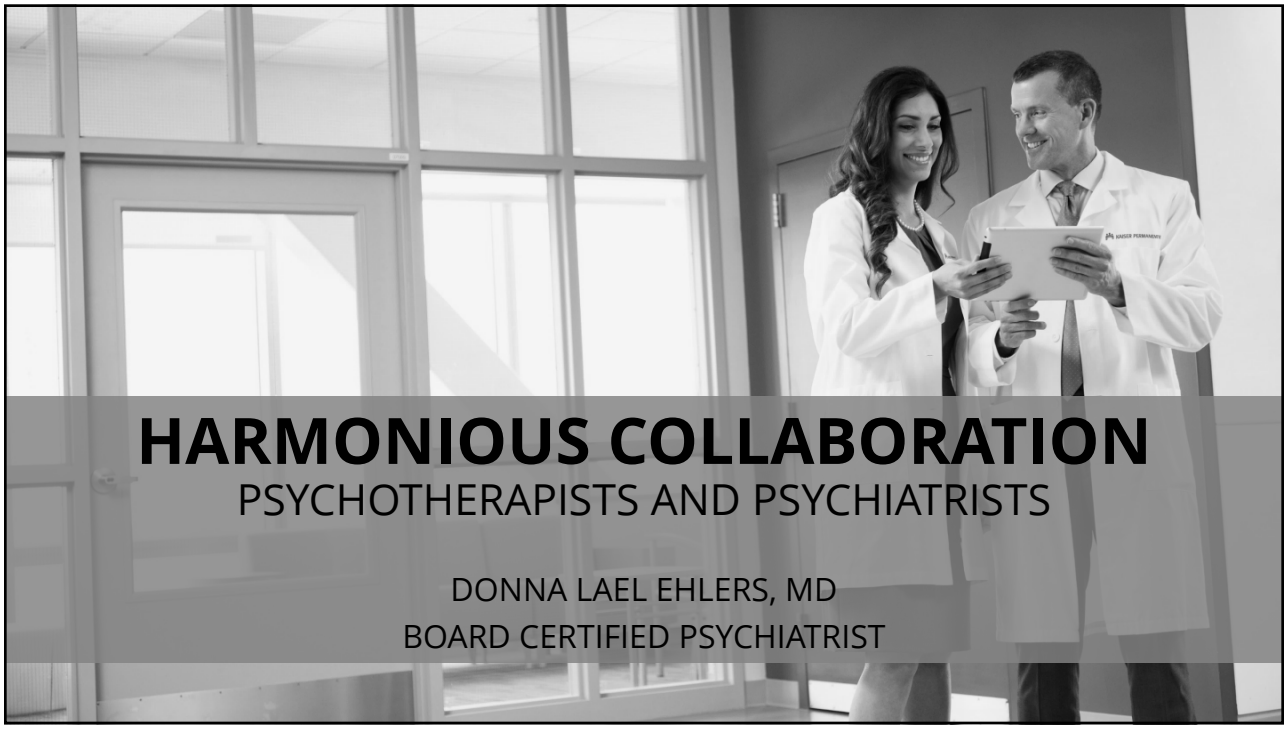


HARMONIOUS COLLABORATION

PSYCHOTHERAPISTS AND PSYCHIATRISTS

DONNA LAEL EHLERS, MD
BOARD CERTIFIED PSYCHIATRIST

PRACTICE VENUES

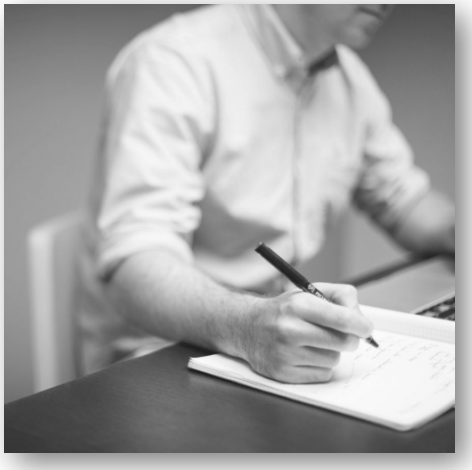
- Private Practice
- Group Practice (HMO)
- Government Employment
- VA Affiliation
- Hospital Based Services

COLLABORATIVE EXPERIENCES

- Was it helpful?
- Was it challenging?
- What worked?
- What could have been better?
- What is a growth experience?

PSYCHIATRIC TRAINING

- 4 years of Undergraduate Education
- 4 years of Medical School
- 4 plus years of Residency
- Issues of Social Isolation
- Taking responsibility for outcome



THE MANY BENEFITS OF COLLABORATION

- Expending horizons continually tests our prejudices and thus adjusts our understanding
- Aids in service planning
- Consult on issues of safety and risk
- Discuss developmental concerns
- Collaborate on behavior and mental health assessment

BENEFITS

- Address concerning family and social dynamics
- Consider referral options
- Share critical case updates
- Enhance holistic treatment plans
- Encourage adherence to RX plans

BRIEF SUCCINCT CASE PRESENTATIONS

- Formalize presentation in language of Psychiatrists
- Examples see handouts
- Identification, reason or chief complaint, brief history of illness

CASE PRESENTATIONS

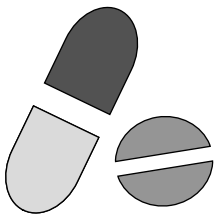
- Medications, Suicide Attempts, Early Trauma, Substance Abuse, Work History
- Past Psychiatric Hospitalizations
- Complicating Factors Including Legal Issues, Medical Problems
- Summarization of MSE and Analysis
- Diagnosis and Treatment Plan

PSYCHIATRIC COLLABORATION

- Be very specific with reason for collaboration i.e.
  - Medication
  - possible crisis resolution
  - mentoring with difficult patient
  - additional opinion
- Clear parameters for ongoing communication
- If appropriate fax insurance info and CV

WHY MEDICATION?

- Prejudice against psychotropic meds
- Symptom understanding from perspective of neurobiochemistry
- Risk/benefit perspective
- Conversation with patient regarding consultation with psychiatrist (energy)



RISKS INHERENT IN COLLABORATION

- Different therapeutic goals
- Lack of trust, respect, admiration of colleague
- Confused, unclear, incomplete communication of patient status
- Documentation in chart is not reflective of communication

COLLABORATION WITH PRIMARY CARE MD

- Depression increases all healthcare costs by 50-100%
- Studies have shown that every 1$ spent on collaborative care saves 6.50$
- Every category of health care costs benefit:
  - Pharmacy
  - inpt and outpt
  - medical and specialty care
- KP studies have confirmed better outcomes

FINANCIAL BENEFITS OF COLLABORATIVE CARE

- Collaborative care with est 20% of Medicaid patients with depression would save over 15 billion $ per year.
- Depression causes interruption in workforce, early retirement and collaboration results in faster return to employment saving Medicaid
- Triple aim:
  - improved health
  - improved quality of care and
  - decreased costs

BENEFITS OF COLLABORATION

1. PHQ-9 for depression allows for stepped up treatment to achieve goals
2. Collaborative care decreases health disparities in ethnic minority groups
3. Higher effectiveness in every category of mental illness as compared to usual care

BARRIERS TO OPEN COMMUNICATION

- Clinician anxiety and shame
- Clinical ambivalence or uncertainty
- Lack of understanding and acceptance
- Lack of respect or trust
- Too much detail and excessive time

COMMUNICATION TOOLS FOR CLARITY

- Formulate a psychodynamic analysis
- Explain countertransference and transference issues with patient
- Treatment plan including therapeutic interventions projected

ESSENTIAL CLINICAL SKILLS TO MANIFEST

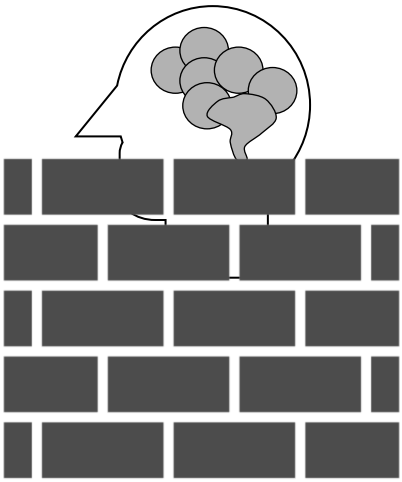
- Clear and concise report of clinical data
- Coherent history
- Clear and accurate representation of what was seen and heard by patient
- Formulation of accurate hypothesis

FAILURE OF COHESIVE COLLABORATION

- Poor match between professionals
- Difficult and confusing clinical picture
- Clinicians have therapeutic strategies for treatment that cause conflict
- Either professional should resign from treatment if necessary for good patient care

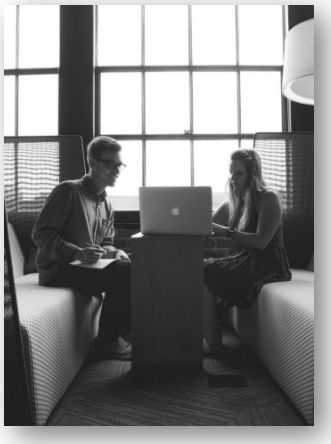
PSYCHOPATHOLOGICAL BARRIERS TO SPLIT RX

- Severe character pathology (splitting)
- Impulsive behavior
- Patients with strong negative transference reactions
- Rapid-cycling bipolar/bipolar depression
- Treatment resistant, dual DG, multiple or off-label drug regimens



BOUNDARY ISSUES

- Discuss emergency coverage during and after work and on weekends, including vacation coverage
- Willingness to communicate and easy accessibility leads to less risk
- Clear responsive system for sharing
- Clarity is best to counterweight interprofessional ambiguity

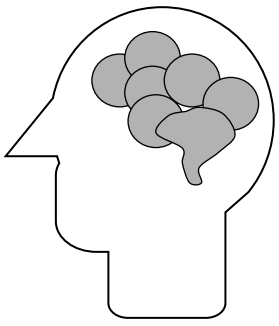


RISK MANAGEMENT ISSUES

- Psychotherapists have increased access and more frequent visits
- Professionals be privy to different types of information and focus of inquiry
- Both are responsible for sufficient direct examination
- Both have responsibility to let other know of changes in clinical picture

TOOLS FOR IMPULSIVE UNRELIABLE PATIENTS

- Most risky patients are those impulsive patients with little insight
- Patients that are inhibited or unmotivated or paranoid about announcing their distress to others
- Foster awareness of high risk situations
- Articulate predetermined responses for patients experiencing deterioration



ASSESSING SUICIDE RISK

- Affective disorder
- Psychotic disorder
- PTSD
- Chronic pain
- Substance abuse
- History of self-destructive behavior

CLINICIANS EXPERTISE

- Risk assessment
  ”How would you know if things were getting worse?
- Mutual responsibility for patient care
- Both are qualified by training and expertise with appropriate clinical judgment and interventions.
- Psychiatrists perspective of liability exposure

BOUNDARY PARAMETERS

- What is my clinical competence and duty to patient?
- What is my relative clinical autonomy?
- What are the areas of clinical interdependence?
- Is there any specific agency or legal statute that has bearing on treatment?

QUESTIONS?

THANK YOU!