



## **Collaborative Treatment (Split Therapy) vs. Integrated Treatment: A Clinical Monograph**

*(Rev. 3/02/02)*

### **SECTION I- OVERVIEW**

#### **Purpose**

The purpose of this document is to provide information to providers and Magellan clinician reviewers to assist them in decisions about the selection of the number of practitioners for individual patients who may require both psychotropic medication and psychotherapy. It is recognized that the patient and his/her providers are ultimately responsible for this decision, yet our clinician reviewers are able at times to provide assistance with these types of questions.

There are two valid systems of care for such patients: collaborative treatment and integrated treatment. This document summarizes the potential respective advantages/disadvantages of both split, collaborative treatment and of combined, integrated treatment. Also discussed are the various patient, illness, and clinician parameters that need to be assessed in order to make informed decisions concerning which arrangement to support in an individual patient's treatment.

**It should always be clear that the provider has sole authority and responsibility for treatment decisions regarding patient care. Magellan clinician reviewers should communicate this information explicitly to providers.**

## Definitions

### *Collaborative Treatment*

This describes behavioral health treatment conducted by at least two independently licensed clinicians, usually a psychiatrist conducting medication management visits and another licensed behavioral health (BH) clinician conducting psychotherapy visits. In this arrangement, the psychiatrist will most often conduct medication management procedures (90862), but may also occasionally conduct medical psychotherapy procedures (90805 and 90807). This arrangement has often been referred to as split treatment, combined treatment, medication backup & psychotherapy, and parallel treatment. In this monograph, this form will be cited as *collaborative treatment*.

### *Integrated Treatment*

This usually describes treatment solely conducted by a psychiatrist, who is both managing the medication and providing the necessary psychotherapy in the same session. Here the psychiatrist is typically conducting 90805 and/or 90807 “medical psychotherapy” procedures.

## Background of Collaborative Treatment

A number of factors have led to the common practice of *collaborative treatment* in the behavioral health field. The specialty field of behavioral health is somewhat unique in medicine in that many patients can be successfully diagnosed and treated by non-M.D. licensed clinicians. One reason is that any type of behavioral health clinician can conduct all types of psychotherapy, provided that the clinician has had the appropriate training and supervised experience. Also, non-physician therapists usually are less costly per session than psychiatrists. Additionally, non-M.D. BH clinicians far outnumber psychiatrists, particularly in under-served rural locations. Furthermore, many research studies have evidenced that better outcomes for many psychiatric disorders are realized if psychotherapy is combined with psychopharmacologic approaches.

Even before "managed care", these factors contributed to the common situation of patients entering the mental health system by selecting a non-M.D. BH clinician- social worker, marriage counselor, psychologist, etc.- and then being referred, if needed, for a psychiatric consultation. It has therefore always been incumbent upon non-M.D. BH clinicians to recognize those patients that require a psychiatric evaluation and to refer accordingly. These referrals would often give rise to collaborative treatment relationships, with the psychiatrist prescribing and managing psychotropic medication in concert with the referring BH clinician continuing the psychotherapeutic treatment.

Limited economic and clinical/medical resources also influenced the growth of delivery systems promoting collaborative treatment, again prior to managed care. Medical directors of community mental health centers recognized that having more plentiful non-M.D. BH clinicians conduct the majority of the psychotherapy, while the fewer psychiatrists served as diagnosticians, consultants, supervisors and pharmacotherapists, led to a quality, cost-effective system of care. This arrangement maximized utilization of the psychiatrist's unique expertise, bringing it to bear on the most patients.

Managed care has attempted to bring a similar efficiency of limited behavioral health resources along with a focus on quality of care, specifically in terms of matching patients to the most appropriate provider(s) at the most appropriate level of care. In the outpatient realm, this would be operationalized with Magellan when Care Managers assist with referral decisions. A typical clinical situation presenting to a provider and a Magellan Care Manager might be a patient with a probable Major Depression and a history of responding to both psychotherapy and medication during a past episode. A decision needs to be made if both forms of treatment may need reinstatement, and if so, whether an integrated or collaborative approach would be the best choice.

## SECTION II- CONSIDERATIONS

### General Principles

*There are no controlled studies that demonstrate that there is a type or class of patient that would do better with either collaborative treatment vs. integrated treatment.* Much of the relevant literature consists of guidelines for clinicians who are in a collaborative treatment relationship.<sup>2,4,5</sup> These articles stress the need for initial and ongoing communication between the collaborative clinicians and the patient. A variety of methods are described in these articles about how to conduct this communication. These articles further emphasize that each clinician's respective role should be clarified to all parties, and that the patient provide full informed consent for such open communication. There is agreement in the literature that less than open communication between all three parties could lead to significant problems in the treatment. It is also clear that both clinicians in such a relationship need to be fully aware of the other's treatment, and needs to take responsibility for their own defined roles.

To date, there are only two relevant articles comparing relative costs of collaborative treatment vs. integrated treatment, yet each has its limitations.<sup>7, 11</sup> These articles did find a lower cost for integrated treatment, but there was no data on the respective clinical outcomes of the two groups. Therefore, the scientific literature is insufficient to support that either type of treatment arrangement produces better outcomes or is more cost-effective if all other factors are equal. Therefore, the provider and Magellan Care Manager need to consider a variety of factors when discussing the provider's treatment plan for such patients. Such a careful evaluation of a number of factors will assist the provider in determining which treatment type may be more advantageous. If it is clear that the patient won't likely require medications, then the best approach may be using the single clinician of any degree type that appears to be the best match for the patient's needs and preferences. This decision should also be informed by considerations of other reasons to refer to a psychiatrist that are detailed in another Magellan clinical monograph entitled *Psychiatric Consultation: A Clinical Monograph*.

## Factors to Consider

In situations where the patient may require medication and psychotherapy, the provider and the Care Manager need to weigh the following factors in order to assist the patient in making an informed choice of collaborative vs. integrated treatment.

1. *Clinical.* Again, there are no published studies that demonstrate what clinical situations will have the best clinical outcomes in collaborative vs. integrated treatment. Therefore the provider needs to use his/her clinical judgement to render a decision on clinical grounds for each case. A patient that may do better in integrated treatment, all other factors being equal, may be an acutely psychotic patient with a history of multiple recent hospitalizations. Another patient that potentially would do better in integrated treatment might be a personality-disordered, depressed, self-mutilating patient who is not progressing in collaborative treatment of many months duration, and the current clinicians believe that a significant part of this lack of progress is the patient's avoiding psychotherapy sessions due to the use of splitting.
2. *Clinician factors- expertise, trust and recommendation.* Clearly one of Magellan's strongest values is to match patients with the most appropriate provider at the most appropriate, least restrictive level of care. If a patient is suffering from a disorder that usually has the best outcomes from a specific type of psychotherapy (e.g. CBT for Bulimia, Desensitization for Phobia), then strong consideration must be given to the expertise of the clinician conducting the psychotherapy. Additionally, it is crucial that the clinicians in a collaborative relationship share a trust and respect for each other's abilities. If unknown to each other at the outset, they need to communicate sufficiently in order to develop this trust. When collaborating therapists work in a multidisciplinary group located in the same office, chances are much greater that they have this mutual awareness and trust already. If a decision is made to change the treatment plan from a single clinician to a collaborative relationship, then the Magellan Care Manager should consider whether the current clinician has a preference of an already known to them, trusted In-Network clinician, if all other factors are equal.
3. *Financial.* Some patients may have difficulty affording the co-pays for two different clinicians. Also, if prone to crisis, some patients may require more than weekly visits, and the co-pay burden might become very significant if in a collaborative treatment arrangement. Additional transportation costs to collaborative clinicians may also be a factor.
4. *Job and Family.* Consideration should be given to the patient's job and family responsibilities and thus the ability to take absences from work/responsibilities to attend appointments with two different behavioral health clinicians. If this is a significant factor for a particular patient, than this may be a factor in favor of integrated treatment. If a certain treatment and situation relies heavily on a family assisting with medication compliance, a psychiatrist conducting medical psychotherapy may be better positioned to accomplish this.

5. *Patient preference.* If not outweighed by a significant clinical factor, it is of utmost importance that the patient is in agreement with the recommendation. Often patients have preferences relevant to gender, professional degree, ethnicity, and cultural background of the clinician. It has been suggested in the literature that cultural matching, if requested by the patient, may assist in compliance with treatment.<sup>19</sup>
6. *Transportation.* Some patients use public transportation or require assistance with transportation, and it may be less of a hardship to travel to only one clinician, also potentially enhancing patient compliance. When collaborative clinicians are in the same office, transportation problems are minimized.
7. *Location.* Patients in rural settings may have greater distances to travel to see a psychiatrist, and therefore, would potentially be better served in seeing only one clinician.
8. *Access.* Due to a low supply of psychiatrists and/or psychiatrist appointment time in many communities, the available appointments with local psychiatrists are on occasion insufficient to support integrated treatment, so collaborative treatment may be a better alternative. The practice patterns of psychiatrists in a community may also affect availability, if many psychiatrists are in predominantly psychopharmacologic practices with limited medical psychotherapy hours.

## Summary

In conclusion, patients have the potential to receive the highest quality behavioral health care in either collaborative or integrated treatment arrangements. The scientific literature reveals that each form has its advantages and disadvantages, and offers guidelines for clinicians in collaborative relationships to maximize the effectiveness of that form of treatment system. Such guidelines are summarized in the “General Principles” section of this document. There is insufficient data currently to make general conclusions about the relative cost-effectiveness of either system. Individual cases warrant consideration of multiple factors in order to make the most informed decision about the best treatment arrangement to select. This paper guides providers and clinician reviewers through those factors, whenever the occasion arises to make such decisions.

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## Collaborative Treatment/Integrated Treatment: Relevant Factors Grid

FACTOR	COLLABORATIVE TREATMENT	INTEGRATED TREATMENT
<b>Clinical</b>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. More therapist resources available to patient.</li> <li>2. During clinician vacations, another clinician who is familiar with patient can share the coverage</li> <li>3. Chance for clinicians to learn from each other.</li> <li>4. More clinical history obtained by two different clinicians.</li> </ol>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. Certain complex, severely ill patients may be better managed (e.g. acutely psychotic patients, personality disordered patients prone to splitting).</li> <li>2. Psychiatrist is able to recommend and conduct the total treatment he/she feels is appropriate.</li> <li>3. Patients with co-morbid medical conditions contributing to or complicating treatment of mental illness may be better managed</li> <li>4. Potentially better ability to involve family in medication decisions and compliance.</li> <li>5. No potential communication problems between psychiatrist and psychotherapist.</li> <li>6. No potential for transference or countertransference problems between clinicians.</li> </ol>
<b>Clinician Expertise &amp; Trust</b>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. Better numerical chance to match psychotherapist's expertise with clinical needs.</li> <li>2. If psychiatrist and therapist work in same practice, better chance of knowing each other's work and having mutual trust and confidence.</li> </ol>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. If psychiatrist is expert at needed psychotherapy, then one clinician has matching broad range of expertise to bring to bear.</li> </ol>

FACTOR	COLLABORATIVE TREATMENT	INTEGRATED TREATMENT
<b>Financial</b>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. May be more cost-effective for the healthcare system.</li> </ol>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. May be more cost-effective for the healthcare system.</li> <li>2. Less co-pay burden and transportation costs to patient.</li> <li>3. Less loss of pay from missed work.</li> </ol>
<b>Job &amp; Family</b>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. May involve a BH clinician with more available time to schedule family visits.</li> </ol>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. Less time away from job and family responsibilities.</li> </ol>
<b>Patient Preferences</b>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. Patient may have better chance for a gender/cultural match, if preferred.</li> </ol>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. Some patients may prefer an M.D. for all treatment.</li> <li>2. No chance that one clinician who is not a gender/cultural match will be undervalued compared to another clinician who is a match.</li> </ol>
<b>Transportation</b>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. If clinicians are co-located, then transportation is similar to the convenience with one clinician.</li> </ol>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. Transportation may be less costly and more convenient.</li> </ol>
<b>Access</b>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. Non-psychiatrist appointment times are generally more available.</li> </ol>	<p><b><u>Advantages</u></b></p> <ol style="list-style-type: none"> <li>1. May be less difficult to find convenient appointment times if only one clinician necessary.</li> </ol>