The Role of Psychotherapy in Integrated Care

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The current emphasis on integrated psychiatric and medical care for people with mental illnesses raises hopes for more favorable clinical outcomes as well as concerns about the quality of the actual care being delivered. The author writes from the perspective of a long career as a psychiatrist and psychoanalyst in a full service medical building in which communication and, at times, collaboration between mental health and general health providers yielded significant benefits to patients. Psychotherapy played a major role in these favorable outcomes, as did accessibility to general medical services when needed and working relationships between physicians of different specialties. However, conditions in current integrated systems pose seemingly insurmountable obstacles to offering full service psychiatric care. The overwhelming disproportion between the numbers of patients in serious need and the available psychiatric resources creates wrenching clinical dilemmas. The hard-nosed administrative approaches to the challenge appear to leave out the factors of human relationships and the conditions necessary for effective psychotherapy beyond simple triage and ultra-brief supportive therapy in crises. Where it is possible for psychiatrists to work closely with other physicians, certain conditions are necessary to maintain the integrity of the psychotherapeutic relationship and the psychiatrist's psychotherapeutic skills. *(Journal of Psychiatric Practice* **2014;20:466–469**)

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Integration is the "next best thing" in psychiatry and mental health care. It takes several forms. The theme of the American Psychiatric Association's (APA's) recent Institute on Psychiatric Services in San Francisco was "Integrating Science and Care in a New Era of Population Health." Integration of mental health care and primary care is receiving much attention. "Collaborative care" and "population health" were featured in a recent edition of Psychiatric News.[1] Almost 20 years ago, I served on an APA task force chaired by Steven Sharfstein that derided the fragmentation of mental healthcare services—separation of various components of service for severely and persistently mentally ill people into separate "silos" that all too often led to breakdowns in continuity of care and poor clinical outcomes. Thus, integration of the various mental healthcare system components that provide care to these patients is a high priority, as reiterated by Sederer and Sharfstein a few weeks ago in a JAMA Viewpoints statement.[2] All of these forms of integration intuitively make a great deal of sense for dealing with the enormous challenge of providing effective treatment of all kinds to the vast number of people who need it and whose psychiatric problems are accompanied by a high incidence of serious medical illness. A recent APA Board of Trustees report on the role of psychiatry in healthcare reform emphasizes that psychiatry must play a major role in crafting the rapidly evolving healthcare systems, in which integrated care is a critical component.[3]

I approach this topic from the perspective of an old-timer whose psychiatric residency began in 1960 after an internship in internal medicine. At that time, Western Reserve University (now Case Western Reserve University [CWRU]) School of Medicine had introduced a revolutionary new curriculum in which the basic science was organized around organ systems rather than departments or disciplines. The "Mind" was treated as an organ system. The clinical training began in the first year, as the student was assigned a pregnant woman as a patient, whom the student would follow throughout the pregnancy and the first years of the child's

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life. Psychiatrist-psychoanalysts were extensively involved in the design and execution of the curriculum as well as the clinical experience. Close working relationships evolved between the psychiatrists and the internists, gynecologists, pediatricians, and even the surgeons. The patients in those clinics indeed received integrated care. Research was developed on illnesses thought to be psychosomatic and on the emotional aspects of coping with pregnancy or severe or chronic medical illnesses. Pediatric wards were opened around the clock to the families in a dramatic change of policy that was influential around the world, and child life workers came into being. University Hospitals (UH) established a therapeutic nursery school to deal with developmental problems of early childhood, which later became the Hanna Perkins Center. Anna Freud visited more than once and addressed the medical students.

After 5 years on the full-time staff of UH, I went into private practice and spent most of my career in a full service medical building staffed by UH/CWRU physicians, many of whom I had worked with during my internship and sometimes as a consulting psychiatrist. My consultation-liaison training in residency had included some liaison experiences with individual units on other services, allowing me to become somewhat attuned to the group psychodynamics of a specific unit as well as the problems of its various patients. Later in my practice, psychiatric colleagues and I lunched with all kinds of specialists and did a fair number of corridor consultations on a practical level. I learned what to communicate and how to be helpful, while sharing patient information only on a "minimum necessary" basis with the patient's permission. I picked up some newly emerging general medical problems in my patients and helped others deal with the emotional consequences of their medical or surgical illnesses.

I provided continuity of care to many patients with individualized adaptations of psychodynamic psychotherapy—short- and long-term—and took several dozen patients into psychoanalysis over the years. Those patients who were prescribed psychotropic medications took them faithfully and responded to moderate doses; the ongoing relationship with me as a physician undoubtedly sustained their engagement in treatment, even when we eventually only met infrequently or prepared for termination. I heard from some many years, even decades, later to fill me in on their lives. Sometimes their internists kept me posted. I would not say that this was "integrated" care, but it entailed mutual respect and sharing of medical responsibility among professionals working well in their own domains. I could imagine this model of care taking place in the framework of a so-called "medical home."

I would not want to see integrated care result in a mix of mediocre psychiatry with mediocre medicine. Another risk could be failure to distinguish the special characteristics of a patient's relationship with a psychiatrist from that with a non-psychiatric physician. Ultimately, there is the danger that, in the new "population health" model, the psychotherapy skills of the psychiatrist would atrophy from misuse, depriving patients of a core element of effective, individualized psychiatric care.

The APA Board report cited above[3] unequivocally foresees a major overhaul of healthcare delivery that relies heavily on large systems of care, use of electronic means for maintaining records and tracking performance, reimbursement linked to performance when it is fee-for-service, altered procedural coding, and full integration of "behavioral" health services with the rest of medical services. Psychiatry must play a major role in developing and managing this system. Because of the severe shortage of psychiatrists in the face of an overwhelming need for services, a significant part of psychiatrists' role will be leadership, management, and teaching of primary care providers. Psychologists, social workers, and other "behavioral" health specialists will also be collaborating with primary care providers.

The report notes that patient records concerning mental illness and substance use disorders are already "embedded in existing EHRs [electronic health records]" because most patients are "seen primarily in the general medical sector. There is a lack of EHR products available for behavioral health settings that can ensure adequate confidentiality." "Health information technology should be a priority focus…" adds the APA report, noting that widely publicized revelations of large amounts of personal health information have made patients wary. That is an understatement. Patients must be sure of confidentiality or they will not be open about what is happening in their minds. Unequivocally in my view, psychotherapy notes must be explicitly sequestered and totally firewalled in an EHR, or preferably maintained totally separately by the therapist, outside of the electronic system.

Accountable care organizations, medical homes, and other innovations are just now in the process of being formed in the private sector, seemingly organized around existing large organizations such as hospitals and insurance companies. States are reworking their Medicaid and other programs, as suggested for New York State by Sederer and Sharfstein.[2] However, the huge Veterans Administration Health System (VAHS) is already in the thick of it. A PubMed search brings up a long list of reports on the VAHS systemic approach to delivering "behavioral" health services in primary care settings.

In looking for reports about the experience of people working in the trenches, not much appears to have been written. Nevertheless, one detailed study based on a survey of mental healthcare professionals in the VA system working in primary care facilities gives an enlightening account.[4] The fourteen "behavioral health providers" (BHPs) who responded represented 48% of the BHPs in that particular regional VA network; they were asked about their perceived role as co-located, collaborative care providers. Significantly, none of the respondents was a psychiatrist. Eight were social workers, five were psychologists, and one was a psychiatric nurse practitioner. I was impressed at how dedicated these professionals were in doing their best to serve a large population under very trying circumstances. Some of their comments are quoted in the narrative presentation of the results. The difficulties were partly inherent in the effort to provide community-based care: the facilities are spread across a geographical region that posed "logistical and travel barriers" when patients needed referral to specialty mental health services. There was wide variability in the degree to which actual collaboration with primary care providers was possible. Open access schedules were disrupted by crisis situations, which of course is not unique to the VA system. BHPs developed "local workarounds to address wait times for specialty mental health services." "Patient complexity impacted BHPs' ability to provide focused, brief treatment." "Communication with primary care staff was the single most important factor in developing working collaborations, with BHPs adopting a highly flexible stance in finding ways to communicate with medical providers." The structured electronic record protocols were helpful in guiding the BHPs through the numerous categories of data they were expected to collect, whether pertinent to the case or not. The time required to go through the entire procedure kept them from being able to talk flexibly with patients as much as needed. (Primary and specialty care doctors have also complained bitterly to me about this—no one likes EHRs very much.)

My search also led me to a recent review[5] of a book about integrated care published by American Psychiatric Publishing.[6] The reviewer, Mark Ragins, calls this an "excellent, very practical book" that addresses the integration of behavioral health into primary care and of primary health care into community mental health centers. Each chapter has "something special to offer." The material is very specific and factual. The model is a psychiatrist working 2 hours a week "along with a full-time BHP embedded in a busy primary care practice serving 2000 patients, very rarely meeting any of them, focusing instead on managing screening tool scores and appointment compliance." A parenthetical aside early in the review—"relationships are not important in this book"—gives a clue as to where this reviewer is going to come down. He elaborates: "Unfortunately, the clearer this vision of the future is made the more horrified I became; This is a dystopian vision for me." I would have to quote the rest of the review to express the concerns with which I resonate on contemplating this vision of the future. As "a community psychiatrist reluctant to practice primary care," he likes the final chapter, a step-by-step guide to treating primary risk factors. I recommend reading the review and perhaps (without having yet read it myself) the book.

The promise of integrated care should not founder on a cold-blooded systems approach. Understanding systems and population medicine are essential, but so also is preserving the core of our identity as psychiatric physicians. Individual human beings are the reason for all of health care to exist; systems are only a means to provide them with the care they need. Relationships are the foundation of providing medical care, and talking with our patients skillfully is at the core of effective psychiatry. That also applies to relationships among professionals working together.

If we are to make integrated care work and still preserve our role identity and skills as psychiatrists, we must make sure that psychiatrists spend some of their time with patients and have protected hours to conduct psychotherapy. Beyond the supportive ther-

apy that almost inevitably accompanies effective patient care, full-scale psychodynamic or cognitive-behavioral therapy should be available to patients who could benefit from it, and psychiatrists should conduct some of it rather than leaving it all to psychologists and social workers. Electronic records should be our servants, not our masters—practical, sensible, and tailored to the kind of service being offered. Psychotherapy notes must be fully separate, as stated by the Health Insurance Portability and Accountability Act (HIPAA) and guarded by the confidentiality and absolute privilege stated in the 1996 Supreme Court decision in *Jaffee v. Redmond*.[7] Conscientious psychiatrists and other mental health professionals struggle to meet the needs of patients as described in the VAHS study mentioned earlier, but we need more of them and they should be paid in a way that is commensurate with their investment in learning and of themselves that characterizes good medicine and good therapy.

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