

*Hogg Foundation for Mental Health*  
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Presentation Notes  
Lucius Ripley MD  
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When I finished medical school, I originally intended to go into family practice. During the course of my internship year, I developed a respect for the incredible breadth of knowledge required to function as a primary care physician, but decided I would be better off working in a more specialized field. The extreme “breadth” of knowledge required inevitably means some sacrifice in “depth,” so it should be a natural occurrence for generalists and specialists to work together in the interest of patient care. Over the years, in spite of much contact with primary care physicians and other specialists during the course of my practice, I would say that true collaboration has been rare.

This lack of collaboration stems from many factors, among them:

- the belief that different specialties and specialists have totally separate concerns (almost a deliberate avoidance of collaboration, a lack of a shared sense of responsibility for caring for the “whole patient”)
- logistical difficulties which tend to limit communication among different doctors (lack of time, availability to take phone calls, etc.)
- differences in attitude, philosophy among different medical fields, with corresponding differences in background and training, making communication more difficult

The opportunity to work at Lone Star presented me with a unique situation, one in which I would be working in the midst of a primary care clinic, with the opportunity to share patient care responsibilities with the primary care staff. The CEO made it clear that he didn't really “want” to hire a psychiatrist, but he felt forced to by a combination of circumstances. There were increasing complaints from primary care doctors that they were being asked to see complex psychiatric patients who were no longer being served by the local MHMR. Various federal and other governmental regulations mandated the provision of mental health care. Various organizations, including the Hogg Foundation, wanted to give additional grants to the organization, but required the provision of more mental health services than were currently being offered.

When I first started working in the primary care setting, it took me a while to grasp the “world view” of the primary care docs, and to understand their (variable) level of training and experience in dealing with psychiatric issues. In the beginning I saw patients mainly as referrals from primary care. There were also a number of “outside” patients seeking psychiatric treatment who came to the clinic, and I would refer a number of them to the primary care providers (PCPs) for their primary care needs. There was a sense of separation between primary care and my specialty mental health practice.

Over time, this “co-location with referral” model has developed into a more fully collaborative model. There are still barriers and boundaries, but fewer than there were initially.

Collaboration between primary care and psychiatry takes two main forms:

-Direct consultation by the PCP with me about patients with psychiatric symptoms, and often overlapping medical concerns/treatment issues

-Direct consultation by me with the PCP concerning medical aspects of their treatment

(Occasionally, I will see a patient in the exam room with or without the PCP for brief evaluations and medication recommendations, usually a “complex patient” who is about to be scheduled to see me but who needs immediate psychiatric attention.)

An example of the first sort of collaboration:

*Dr. Smith stepped into my office to ask my opinion about Julie, a 28 yo woman he had been treating for “depression and anxiety.” Two months ago he had started her on an SSRI, and she was doing much better a month later. But today, she is saying she feels just as depressed as she did to begin with. He plans to refer her to me, but in the meantime wants some suggestions about what to do next. I advise him to get more past treatment history, family history, and to administer a depression and bipolar symptom rating scale. As it turns out, this patient had been on 3 previous antidepressants, with similar temporary response patterns, and she had a depression score in the severe range. Her bipolar screening was “positive”, suggesting a high probability of a disorder such as Bipolar II, in the absence of frank mania. And it turned out that, while not diagnosed, her mother had severe “mood swings”, but had always resisted any treatment.*

*Given this further history, I recommended that Dr. Smith start a mood stabilizer with antidepressant properties instead of another standard antidepressant, and by the time I could see her in 3 to 4 weeks it would be possible to decide if that particular drug was the best one for her.*

An example of the second sort of collaboration:

*I am seeing a patient with depression, migraines and hypertension. Her blood pressure has been somewhat elevated, and migraine headaches have recently been more frequent. I want to change her antidepressant medication since she has not responded adequately, but at the same time am concerned that her headaches may be contributing significantly to her depressive symptoms, and the new antidepressant could also raise blood pressure further; is there something else that could be done about them? I confer with her PCP during a break in his schedule; he suggests a modification in her migraine prevention treatment, using a medication which will also serve the dual purpose of lowering her blood pressure.*

These types of collaborative interactions occur frequently in our clinic.

The type of brief, on-demand, behaviorally-oriented consultations with a “Mental Health Specialist” described in the integrated care literature, however, do not occur. The needs of the primary care doctors in our system and of our patient population revolve around the management of relatively complex patients with psychiatric symptoms, not those with behavioral issues related to their medical treatment, or more minor symptoms.

The primary care providers have also become comfortable in using diagnostic tools (rating scales), and in using some newer medications with which they had previously been unfamiliar. This is a direct result of hands-on collaboration, giving them the knowledge and the confidence to make diagnoses and use treatments which previously seemed out of their realm. This of course greatly facilitates my work.

Further improvements in collaboration will I believe be facilitated by the use of electronic medical records, allowing much greater clarity (i.e., you can read the notes) and ease of information exchange as a supplement to face to face interactions. A new building will bring more providers into closer proximity, which will further the process of collaboration as well. A new adult therapist has recently joined the staff, who should be able to contribute not only in terms of providing individual therapy, but also with brief behavioral interventions.

In summary, I believe that we have made substantial progress in developing a collaborative relationship between primary care and psychiatry at our clinic. At the same time, some of my practice remains “specialized” and “separate,” due to the unmet need for psychiatric services in the community (for example, I see a substantial number of patients with insurance who receive their primary care services elsewhere, but are unable to access other psychiatrists). I am hopeful that the synergistic effects of this collaboration will continue to improve the quality of mental health services, which can only help improve the quality of primary care services as well.