The mental health clinic: a new model

GIOVANNI A. FAVA, SEUNG K. PARK, STEVEN L. DUBOVSKY

Department of Psychiatry, State University of New York at Buffalo, 462 Grider Street, Buffalo, NY 14215, USA

The role of psychiatrists into public mental health clinics has been hampered by a perceived restriction of the psychiatrist's role to prescribing and signing forms, limiting opportunities to engage in the kind of integrated care that attracted many physicians to this specialty. We propose a revision of the current model in a direction that maximizes the expertise of this specialist as well as other clinicians in the health care team. The basic unit would consist of a psychiatrist (with adequate background both in psychopharmacology and psychotherapy), an internist and four clinical psychotherapists, who may provide evidence-based treatment after the initial evaluation of the psychiatrist. Its functioning would emphasize repeated assessments, sequential combination of treatments, and close coordination of team members. Re-invigorating the role of the psychiatrist in the context of a team in which role assignments are clear could result in better outcomes and enhanced recruitment of psychiatrists into the public sector.

Key words: Mental health clinic, role of psychiatrists, sequential treatment, integrated care

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In contrast to the decades-long tradition of a biopsychosocial model, many mental health clinics have adopted a model that promotes a split between biological and psychosocial treatments. Following a single initial assessment, psychiatrists see patients briefly for "medication checks", while non-medical clinicians provide psychotherapy. Team meetings occur to ratify treatment plans, but there is little time available for integration of pharmacotherapy with other treatment modalities.

In the US, the split model of care has principally been driven by a shortage of psychiatrists and by reimbursement protocols that are based on the unsubstantiated premise that it is cheaper to pay psychiatrists to write prescriptions and other clinicians to provide psychotherapy than it is to pay psychiatrists to provide comprehensive patient care. One outcome of this approach is that the domain of the psychiatrist is increasingly restricted only to prescribing medications, a service that itself is seen as so straightforward that a minimal amount of time is needed after a diagnosis has been made. To the extent that prescribing psychotropic medications is an uncomplicated process, nurse practitioners and other clinicians with prescribing authority have been recruited to replace rather than supplement psychiatrists on the grounds that they cost less and that they are just as effective – a belief equally unsubstantiated by any credible data.

In the UK, a dramatic example of the relegation of the psychiatrist to a marginal role was the proposal by Lord Layard (1) that led to expanding psychological therapy for anxiety and depression in the British national health system. In this initiative, a senior non-physician psychotherapist would make initial diagnoses and assign the patient to a junior therapist, who would be supervised, motivated and trained by senior therapists. Psychiatrists would be elsewhere in the national health system, with the task of administering drug treatment to the most severely ill patients, and would not be involved at all in the treatment of most mood and anxiety disorders.

There are a number of features of the treatment process

that may also limit the role of the psychiatrist and inhibit comprehensive treatment. For example, in the current clinic model which is endorsed in many contexts worldwide, a diagnosis and treatment plan that are usually developed after a single initial visit are supposed to be followed in the subsequent months or years without any additional time for re-evaluation. This approach is based on a unidimensional, cross-sectional view of the disorder, assuming that the illness does not evolve and the diagnosis does not change over time. Yet, it is not uncommon for apparently clear-cut major depression to be re-diagnosed as bipolar disorder (2-4), because the prodromes of the manic episode were overlooked or masked at the initial assessment (5). Accurate diagnosis and effective treatment often depend on repeated assessments, but in some clinic settings there is insufficient time available to the prescriber for this process (5). Even if the therapist had sufficient expertise to refine the diagnosis, time and structure are not available for a collaborative discussion with the prescriber for comprehensive reconsideration.

Another common issue involves medical evaluation. Between 20% and 50% of psychiatric patients have active medical illnesses (6,7) and psychiatric medications such as some atypical antipsychotics pose additional medical risks (8). A full understanding of the patient's medical condition is important not only to clarify psychiatric symptoms, but also to determine the need for general medical care and to choose psychiatric treatments that do not interact adversely with the medical illness and its treatment (9). It is axiomatic that a medical diagnosis depends on a careful history and physical examination, with laboratory investigations as indicated (9). Yet, such evaluations are rarely performed in the clinic setting by psychiatrists or anyone else (10), despite their responsibility for the overall health of their patients (11). Indeed, psychiatric outpatient clinics generally operate in isolation from the rest of the medical system.

Recovery has increasingly become a stated goal of mental health treatment (12), but there is increasing awareness that

complete remission of symptoms and restoration of normal function is not frequent in such psychiatric disorders as major depression (13), panic disorder (14), obsessive-compulsive disorder (15), eating disorders (16) and schizophrenia (17). For example, only 28% of patients with fairly uncomplicated unipolar depression receiving flexible doses of citalopram were found to be symptomatically (let alone functionally) remitted (18). Lack of remission is associated with subsequent relapse, while treatment of residual symptoms may improve functioning and reduce the risk of relapse and recurrence (5).

Combinations of medications and of psychotherapy and pharmacotherapy can improve remission rates (19). In some cases, treatments that are administered in sequential order (psychotherapy after pharmacotherapy, psychotherapy followed by pharmacotherapy, one drug treatment following another or one psychotherapeutic treatment following another) may be more successful in eliminating residual symptomatology than introducing all treatments at the same time (20). Maximizing remission requires repeated assessments, modification of initial treatment plans and efficient integration of treatment team members, which requires more time than is usually allocated.

Psychotherapy is an obvious component of treatment in the mental health clinic, and over the past two decades there has been impressive progress in the effectiveness of short-term psychotherapeutic strategies such as cognitive behavioral therapies and interpersonal therapy in a number of psychiatric disorders (21). These psychotherapies have been found to be effective alternatives or supplements to pharmacotherapy, with enduring benefits after treatment is discontinued (20,21). However, while many clinics provide psychotherapies in various forms, true manualized evidence-based psychotherapies are often not available, and coordination with pharmacotherapy is rarely possible for most patients, because of brief "medication check" visits to psychiatrists that leave no time for consultation with therapists.

A NEW MODEL

One way to develop a model of more comprehensive and integrated outpatient mental health care is to consider a mental health clinic affiliated with an academic department of psychiatry or other psychiatric organization in the community. Referral sources may be psychiatric inpatient units, psychiatrists in other settings, primary care physicians and other medical specialists or other agencies, or patients may refer themselves. We will discuss the staffing, functioning and modalities of integration of the basic operational unit of the clinic, which could be multiplied according to the number and needs of the patients served.

The basic unit includes a psychiatrist, an internist, and four psychotherapists, who could be clinical psychologists, nurse clinicians or social workers. The psychiatrist should

have an adequate background both in psychopharmacology and psychotherapy. Experience in performing psychotherapy is essential, whether or not the psychiatrist will provide it in the clinic, since referral to psychotherapy requires a deep understanding of the indications, contraindications and expectations of the psychotherapeutic technique that is proposed.

The internist should be able to provide specialized medical evaluation, especially of endocrine and cardiovascular problems. Psychotherapists may have different levels of experience and training in evidence-based psychotherapeutic strategies (21). Individual, family or group formats may be performed, according to the needs of the patients and the skills of the therapists (22). Properly trained clinical psychologists and social workers may be most experienced at individual and group psychotherapy. Nurse clinicians, in the long-standing experience of the Maudsley Institute (23), may be the most appropriate individuals to supervise self-therapy approaches such as exposure, to monitor stable medication regimens, and to emphasize the role of the patient in the process of recovery (13), including diet and exercise (24). To illustrate the functioning of the clinic, consider the entry of a new patient into the system.

The initial assessment is performed by the psychiatrist. In addition to the customary psychiatric examination to determine categorical and dimensional diagnoses (9), the task of this assessment is to establish treatment priorities, since many patients qualify for more than one diagnosis (25-27).

The process of assessing the relationship between co-occurring syndromes to decide where treatment should commence is called macro-analysis (28,29). For instance, a patient may present with major depressive disorder, obsessive-compulsive disorder and hypochondriasis. In a macro-analysis, the clinician may give priority to the pharmacological treatment of depression, leaving to second stage assessment the determination of whether obsessive-compulsive disorder and hypochondriasis are epiphenomena that will resolve with resolution of depression, or whether they will persist, despite improvement of depression. In the latter case, it will be necessary to determine whether further treatment is necessary. If one syndrome is addressed initially, macro-analysis requires re-assessment after the first line of treatment has been completed. Treatment is therefore staged according to the seriousness, extension and course of the disorder (30-33). For instance, certain psychotherapeutic strategies can be deferred until antidepressant medications have improved mood to a point where cognitive reorganization with psychotherapy is more likely to be retained (34). Staging has the potential to improve the logic and timing of interventions in psychiatry, just as it does in many complex and serious medical disorders (31).

The planning of sequential treatment requires determination of the symptomatic target of the first line approach (e.g., vegetative symptoms and mental energy for pharmacotherapy), and tentative identification of other areas of concern to be addressed by concomitant or subsequent treatment

(e.g., dysfunctional thinking and relationships targeted by psychotherapy). Addressing one dimension of illness after an earlier feature has improved can increase the likelihood of more complete remission.

Medical assessment in the psychiatric setting is not as straightforward as in the medical setting (6). Medical evaluation requires familiarity with the interactions of psychiatric illnesses and medications with medical disorders and their treatment, as well as with the complex health attitudes of psychiatric patients (35,36). Collaboration of the psychiatrist with an internist who is familiar with psychiatric illness may be necessary for effective treatment planning when a comorbid medical illness is present.

While macro-analysis involves an assessment of the relationship between co-occurring syndromes, micro-analysis is a detailed analysis of symptoms for functional assessment (28). It involves consideration of the onset of complaints, their course, circumstances that aggravate or ameliorate symptoms, short-term and long-term impact of symptoms on quality of life, and work and social adjustment (28). Micro-analysis may also include specific tests and rating scales (9,37), which must be integrated into the rest of the assessment and not viewed in isolation (38). This dimension of micro-analysis is performed by a clinical psychologist and may either complete the diagnostic assessment or pave the way for further evaluation.

This information should facilitate the formulation of an initial treatment plan, which may involve no need for treatment; referral to other institutions; pharmacotherapy only; psychotherapy only; or use of both pharmacotherapy and psychotherapy, which may be simultaneous or sequential (20).

There is often a tendency to regard simultaneous administration of pharmacotherapy and psychotherapy as the optimal treatment. However, not all data support the initiation of both treatments at the same time, especially in anxiety and mood disorders (20,39). Sequencing pharmacotherapy and psychotherapy may be more effective in chronic and severe cases (39,40). Assignment to the first line of treatment may involve pharmacotherapy provided or monitored by the psychiatrist, psychotherapy provided by a psychotherapist with expertise in the proposed therapeutic modality, or both. However, even when pharmacotherapy alone is the preferred initial treatment, it is less likely to be effective if the patient does not have the opportunity to develop a therapeutic alliance with a prescriber who is sufficiently available to provide appropriate optimism, an opportunity to ventilate thoughts and feelings, and the development of an interest in self-examination (41,42).

If non-pharmacologic approaches are instituted before pharmacotherapy, they may involve sessions by nurse clinicians, emphasizing lifestyle modification, dietary measures, physical exercise, encouragement of exposure and use of computer aided strategies (43,44). Initial psychotherapy may involve cognitive behavioral therapy for panic disorder with agoraphobia, social phobia, obsessive-compulsive disorder or post-traumatic stress disorder; cognitive behavioral

or interpersonal psychotherapy for major depression; or dialectic behavior or expressive therapy for a personality disorder (45). Conversely, certain psychotherapies, for example cognitive therapy for schizophrenia or family focused therapy or interpersonal and social rhythms therapy for bipolar disorder (46), are usually instituted at the same time as pharmacotherapy.

It is very important to reassess the patient after the first line of treatment has been completed, to reconfirm the diagnosis and refine the treatment plan. Certain approaches may limit a satisfactory assessment of the patient in this stage. The first is re-examination of only a few target symptoms, instead of the full spectrum of psychopathology as would be done with a new patient.

The second pitfall is to determine severity by the number of symptoms, not by their intensity, quality or impact on functioning (29). The result is treatment aimed at a diagnosis based on a certain number of symptoms (which may be of mild intensity and of doubtful impact on quality of life), instead of individual symptoms or dysfunctions that may be incapacitating. Conversely, subclinical symptomatology, as frequently occurs in partially remitted disorders (5,13,14), may require aggressive treatment, because it continues to impair functioning and because it increases the risk of relapse or recurrence of the full syndrome (13-15,17).

Another issue is that symptoms are usually elicited through a clinical interview. However, state-dependent recall may limit information available by this method and a diary or daily rating scale can be an important source of information that is not readily apparent in an interview.

Consistent with the principle that health is traditionally equated with the absence of illness rather than the presence of wellness (47), assessment in psychiatry is mostly based on appraisal of psychopathological dysfunction instead of a balance between positive and negative factors (41). To determine whether the patient is well, it is necessary to assess positive health and functioning in addition to symptoms. The most comprehensive reassessment after the completion of psychotherapy and somatic therapy should be performed by the psychiatrist. The assessment performed in this phase is crucial in determining the level of remission after the first course of treatment, whether residual symptoms are present and whether further treatment is necessary. Since the available data suggest that only a minority of patients are likely to display a satisfactory degree of recovery with monotherapy or a single phase of treatment (13,15,17,18), it is often necessary to decide whether psychotherapeutic or pharmacological approaches or both should substitute for or supplement the first line of treatment.

Since any residual symptoms increase the risk of relapse and recurrence (5,13,48), another reassessment is necessary after treatment is completed, for example when a depressed patient has completed psychotherapy following pharmacotherapy (20). If any residual symptoms persist, new treatment strategies, such as indefinite drug therapy and maintenance psychotherapy, should be considered.

At all stages of therapy, integrating treatments requires regular meetings of all team members (including the internist). The goals of these meetings include diagnosis and formulation of treatment plans; monitoring of treatment progress; modification of initial diagnostic formulations and treatment plans; discussion of the role of medical and psychosocial factors; introduction of brief, targeted interventions; supervision of psychotherapy by the psychiatrist or other designated senior psychotherapist; and consideration of maintenance treatment after completion of therapy. The cost of such meetings is compensated for by improved outcomes and less need for multiple episodes of acute treatment after relapse.

CONCLUSIONS

The predominant model of the mental health clinic has the potential to marginalize the psychiatrist to a point that could impede recruitment of this specialist into clinic settings. By making use of the ability of the psychiatrist to synthesize psychiatric, medical and psychological data from diverse sources, interact with different specialists and disciplines, and develop a comprehensive treatment plan, the model proposed here defines a role that many psychiatrists would find desirable while not detracting from the skills of other clinicians working with the patient. Ideological influences that tend to minimize the psychiatrist's role are reduced while maintaining an effective team approach.

We believe that research into the effectiveness of the model would demonstrate that any increase in cost related to using some of the psychiatrist's time for treatment planning, which is normally not directly reimbursed, is offset by more efficient utilization of all services and improved outcomes as well as more successful recruitment of psychiatrists into the public sector.

References

1. Layard R. The case for psychological treatment centres. *BMJ* 2006; 332:1030-2.
2. Dubovsky SL. Treatment of bipolar depression. *Psychiatr Clin North Am* 2005;28:2349-370.
3. Ghaemi SN, Baldessarini RJ. The manic-depressive spectrum and mood stabilization: Kraepelin's ghost. *Psychother Psychosom* 2007; 76:65-9.
4. Benazzi F. Is there a continuity between bipolar and depressive disorders? *Psychother Psychosom* 2007;76:70-6.
5. Fava GA, Kellner R. Prodromal symptoms in affective disorders. *Am J Psychiatry* 1991;148:823-30.
6. Schiffer RB, Klein RF, Sider RC. The medical evaluation of psychiatric patients. New York: Plenum Press; 1998.
7. Sartorius N. Physical illness in people with mental disorders. *World Psychiatry* 2007;6:3-4.
8. Newcomer JW. Second-generation (atypical) antipsychotics and metabolic effects. *CNS Drugs* 2005;19(Suppl. 1):1-93.
9. American Psychiatric Association. Psychiatric evaluation of adults, second edition. *Am J Psychiatry* 2006;163(Suppl.):1-36.
10. McIntyre JS, Romano J. Is there a stethoscope in the house (and is it used)? *Arch Gen Psychiatry* 1977;34:1147-51.
11. Busch KA, Cavanaugh JL. Physical examination of psychiatric outpatients: medical and legal issues. *Hosp Comm Psychiatry* 1985; 36:958-61.
12. Farkas M. The vision of recovery today: what it is and what it means for services. *World Psychiatry* 2007;6:68-74.
13. Fava GA, Ruini C, Belaise C. The concept of recovery in major depression. *Psychol Med* 2007;37:307-17.
14. Fava GA, Mangelli L. Subclinical symptoms of panic disorder. *Psychother Psychosom* 1999;68:281-9.
15. Simpson HB, Huppert JD, Petkova E et al. Response versus remission in obsessive-compulsive disorder. *J Clin Psychiatry* 2006;67:269-76.
16. Bulik CM, Brownley KA, Shapiro JR. Diagnosis and management of binge eating disorder. *World Psychiatry* 2007;6:142-8.
17. Andreasen NC, Carpenter WT, Kane JM et al. Remission in schizophrenia. *Am J Psychiatry* 2005;162:441-9.
18. Trivedi MH, Rush AJ, Wisniewski SR et al. Evaluation of outcomes with citalopram from depression using measurement-based care in STAR-D. *Am J Psychiatry* 2006;163:28-40.
19. Fava M, Rush AJ. Current status of augmentation and combination treatments for major depressive disorder. *Psychother Psychosom* 2006;75:139-53.
20. Fava GA, Ruini C, Rafanelli C. Sequential treatment of mood and anxiety disorders. *J Clin Psychiatry* 2005;66:1392-400.
21. Roth A, Fonagy P. What works for whom? A critical review of psychotherapy research, 2nd ed. New York: Guilford, 2005.
22. Cameron P, Ennis J, Deadman J. Standards and guidelines for the psychotherapies. Toronto: University of Toronto Press, 1998.
23. Marks IM. Behavioural psychotherapy. Bristol: Wright, 1986.
24. Simopoulos AP. Nutrition and fitness. Basel: Karger, 2005.
25. Pincus HA, Tew JD, First MB. Psychiatric comorbidity: is more less? *World Psychiatry* 2004;3:18-23.
26. Maj M. The aftermath of the concept of psychiatric comorbidity. *Psychother Psychosom* 2005;74:65-7.
27. Drake RE, Mueser KT, Brunette MF. Management of persons with co-occurring severe mental illness and substance use disorder: program implications. *World Psychiatry* 2007;6:131-6.
28. Emmelkamp PMG, Bouman T, Scholing A. Anxiety disorders. Chichester: Wiley, 1993.
29. Fava GA, Ruini C, Rafanelli C. Psychometric theory is an obstacle to the progress of clinical research. *Psychother Psychosom* 2004;73: 145-8.
30. Fava GA, Kellner R. Staging: a neglected dimension in psychiatric classification. *Acta Psychiatr Scand* 1993;87:225-30.
31. McGorry PD, Hickie IB, Yung AR et al. Clinical staging of psychiatric disorders. *Aust N Z J Psychiatry* 2006;40:616-22.
32. Fava GA, Rafanelli C, Tossani E et al. Agoraphobia is a disease. *Psychother Psychosom* 2008;77:133-8.
33. Hetrick SE, Parker AG, Hickie I et al. Early identification and intervention in depressive disorders: towards a clinical staging model. *Psychother Psychosom* 2008;77:263-70.
34. Reus VI, Weingartner H, Post RM. Clinical implications of state-dependent learning. *Am J Psychiatry* 1979;136:927-31.
35. Fava GA, Molnar G, Zielezny M. Health attitudes of psychiatric inpatients. *Psychopathology* 1987;20:180-6.
36. Sirri L, Grandi S, Fava GA. The Illness Attitudes Scales. *Psychother Psychosom* 2008;77:337-50.
37. Bech P. Rating scales for psychopathology, health status and quality of life. Berlin: Springer, 1993.
38. Lishman WA. Organic psychiatry, 3rd ed. Oxford: Blackwell, 1998.
39. Otto MW, Smits JAJ, Reese HE. Combined psychotherapy and pharmacotherapy for mood and anxiety disorders. *Clin Psychol Sci Pract* 2005;12:72-86.
40. Fava GA, Tomba E, Grandi S. The road to recovery from depression. *Psychother Psychosom* 2007;76:260-5.
41. Fava GA. The intellectual crisis of psychiatric research. *Psychother*

- Psychosom 2006;75: 202-8.
42. Uhlenhuth EN, Rickels K, Fisher S et al. Drug, doctor's verbal attitude and clinic setting in the symptomatic response to pharmacotherapy. *Psychopharmacologia* 1966;9:392-418.
43. Emmelkamp PMG. Technological innovations in clinical assessment and psychotherapy. *Psychother Psychosom* 2005;74:336-43.
44. Baer L, Greist J, Marks IM. Computer-aided cognitive behaviour therapy. *Psychother Psychosom* 2007;70:193-5.
45. Stone MH. Management of borderline personality disorder: a review of psychotherapeutic approaches. *World Psychiatry* 2006;5:15-20.
46. Scott J, Colom F. Gaps and limitations of psychological interventions for bipolar disorders. *Psychother Psychosom* 2008;77:4-11.
47. Ryff CD, Singer B. Psychological well-being. *Psychother Psychosom* 1996;65:14-23.
48. Rudolph RL. Achieving remission from depression with venlafaxine and venlafaxine extended release: a literature review of comparative studies with selective serotonin reuptake inhibitors. *Acta Psychiatr Scand* 2002;106:24-30.