

Split treatment: Recommendations for optimal use in the care of psychiatric patients

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BACKGROUND: Split treatment refers to the involvement of 2 mental health professionals in the care of a psychiatric patient—one providing psychotherapy and the other psychopharmacologic management. Despite the widespread use of split treatment in outpatient psychiatric care, little data exist on its core features or cost-effectiveness compared with other models of treatment.

METHODS: We reviewed published studies on split treatment, summarized the research database on split treatment, and created principles to guide its use in practice.

RESULTS: Few data-based studies have examined the split treatment model. Both prescribing psychiatrists and psychotherapists have specific and unique concerns and sensitivities in the split model that are likely to affect the overall success of treatment. Among the concerns are respect for the other treating professional, staying within the appropriate boundaries of one's expertise, efficient communication with the co-treater, and parallel accessibility in emergency situations.

CONCLUSIONS: Proper application of split care principles is likely to result in a better-coordinated and more effective approach to treatment of psychiatric patients. Recommendations for future research are offered.

INTRODUCTION

Most outpatients treated with both psychotherapy and medication encounter 1 of 2 kinds of care:

- *integrated*, in which a single psychiatrist is both the psychotherapist and the psychopharmacologist

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- *split*, in which the psychiatrist manages the medications while another mental health professional administers therapy.

Psychiatrists, clinical psychologists, social workers, and psychiatric nurses commonly function as therapists. Having one psychiatrist prescribe medications while another psychiatrist acts as the therapist has become less common, primarily because most psychiatrists currently in practice are comfortable with psychopharmacology and also because of the cost of assigning 2 physicians to the same case. Despite the lack of cost-effectiveness data, it is assumed that split treatment reduces costs. Another type of split therapy, in which a primary care provider prescribes medication without the involvement of a psychiatrist, is increasingly common in some settings and presents distinct challenges that are not discussed in this article.

Over the last few decades, the split treatment model has become the default paradigm in most clinical organizations. This reflects both the greater number of nonphysician therapists available and the differential cost of hiring professionals, with psychiatrists being significantly more expensive than nonphysician therapists. (The differential cost is increased when the therapist has a master's degree in social work or is a licensed clinical social worker or marriage and family therapist vs a PhD in clinical psychology.) For a treatment model that has become so dominant, little attention has been paid to effective protocols for split treatment.

In this article, we review the data on the following issues: (1) the prevalence of split treatment vs integrated therapy; (2) the actual vs theoretical cost savings; (3) the potential difference in clinical outcomes comparing the 2 models; (4) the actual frequency of interaction between the 2 treating professionals as currently practiced; (5) the optimal communication between the 2 treating professionals; and (6) the advantages and disadvantages of the split treatment model from the vantage points of both the prescriber and the therapist. Finally, we provide recommendations for the clinical practice of split treatment.

Prevalence, cost, and differential efficacy

There are few reliable data on the frequency of split treatment vs integrated treatment in community care. A study examining 1995 claims data from a national managed mental health care organization found that, of 1,517 patients receiving both medication and psycho-

therapy, 79% (n = 1,326) were in split treatment.¹ In contrast, a 1997 survey of psychiatrists' practices found that only 29% of their patients were in psychotherapy with another mental health professional.²

The core economic assumptions of split treatment by a psychiatrist and nonphysician therapist are: (1) when 2 professionals are being paid (instead of 1), the higher-fee psychiatrist will see patients less frequently (typically once a month or less for relatively stable patients) than the therapist; and (2) the aggregate cost of the infrequent psychiatrist visits plus the more frequent, but less expensive, therapist visits will be less than it would if the psychiatrist performed both functions. Surprisingly, only 1 study has examined this assumption. In the study using 1995 data cited above,¹ the adjusted mean cost of outpatient services for depressed patients was significantly *higher* in a split treatment group than in an integrated treatment group. This was partly due to the greater number of sessions—both therapy and medication visits—in the split treatment group. Thus, it is possible that split treatment increases the overall frequency of visits.

Dewan³ modeled different split treatment arrangements using median insurance reimbursement rates in 1998 (10 therapy sessions plus 5 medication visits, or 15 therapy sessions plus 3 medication visits) and compared the costs with 5, 10, or 15 therapy sessions with a psychiatrist alone. He concluded that integrated treatment with a psychiatrist costs the same as split treatment with a social worker and a psychiatrist, and was lower than a psychologist/psychiatrist split arrangement. However, the ratio of number of therapy visits to medication visits was 2:1 or less in all 3 scenarios. In current practice with patients who are stable, this ratio is far higher (eg, weekly therapy sessions alternating with medication visits every 2 to 3 months), potentially yielding far greater savings in split treatment.

There are no data on the critical question of whether patients in integrated vs split treatment differ in short- or long-term outcomes. Addressing this question would not only require a comparative effectiveness trial design but also a large enough sample of patients with a greater or lesser need for psychiatry visits. No such studies have been published.

Advantages and disadvantages

Many decades ago, the emergence of split treatment was

TABLE
Advantages of split treatment

• Each treatment modality can stay focused
• Different interviewing techniques may lead to a broader acquisition of clinical data
• Strong patient/clinician transference reactions may be diffused by the presence of 2 mental health professionals
• Changes in the course of the illness over time can be observed by both professionals, leading to earlier identification and treatment of recurrences
• Due to their greater frequency of patient visits, therapists may more rapidly identify instances of medication noncompliance
• Therapists administering treatments that include psychoeducation may enhance the patient's compliance with medications
• The treating psychiatrist may be able to clarify a patient's resistance to therapy and encourage the therapist to address the issue further

greeted with wariness by psychiatrists and nonphysician therapists. Concerns included: splitting, whereby the patient denigrates the other professional; the fear that the psychiatrist might “steal” the patient from the therapist; the concept that therapy might inappropriately stir up the patient's affect, thereby undermining the pharmacotherapy; and the concern that the promise of a quick fix by medication might undermine the patient's motivation for therapy.⁴

Over the last few decades, however, most mental health professionals have become comfortable with split treatment, partly due to their sheer familiarity with it by experience. Many of us have seen the model work frequently enough to be willing to participate in it. Additionally, there is no evidence that pharmacotherapy undermines psychotherapy or vice versa, with the possible exception of benzodiazepines diminishing the efficacy of prolonged exposure or desensitization therapy in anxiety disorders.^{5,6} Instead, there is consistent evidence across a broad range of disorders for the efficacy of combined treatment compared with pharmacotherapy alone (for the evidence in mood disorders, see Geddes and Miklowitz⁷ and Hollon et al⁸). Conceptually, splitting the treatment also may have specific advantages, which are listed in the **TABLE**.

The potential disadvantages of split treatment all reflect the essential nature of dividing the treatment of 1 disorder into 2 separate components.⁹ First, it makes it easier for the patient to denigrate 1 of the 2 treatments

(or treaters). This may be especially problematic with patients with borderline personality disorder, for whom splitting may be a core defense. Second, one of the goals of psychiatric treatment is to help patients understand that both biological and social/environmental factors must be addressed in successful treatment. When these domains become confounded with different clinicians, this integrated view may become more difficult to achieve. Third, although split treatment can effectively address a patient's suicidality (see Case 2 as an example), transfer of important information, such as knowing how many pills the patient has at home or whether he or she has access to weapons, may be lost.

Communication between psychopharmacologists and therapists

Although it would seem appropriate for the prescribing psychiatrist and therapist to routinely have contact with their mutual patient(s), surveys show that this contact occurs less frequently than might be anticipated.¹⁰⁻¹² In a clinic staffed with psychiatric residents, over a 5-month period in 1993-1994, contact between the psychiatric residents and the therapists occurred for just over half of the patients.¹⁰ When contact did occur, it happened only once for one-half of the cases. The contacts were initiated equally by psychiatric residents and therapists. Not surprisingly, when the therapist worked in the same clinic as the psychiatric resident, contact was more frequent, suggesting the importance of proximity as an important factor in maintaining contact.

Kalman et al^{11,12} surveyed private practice psychiatrists about the extent of communication in split treatment. Among psychiatrists with patients in treatment for >6 months, no communication occurred between the 2 treating professionals in 25% of cases. Similar estimates were obtained when surveying the therapists in these cases.¹² Fewer than 20% of the psychiatrists and therapists reported at least quarterly communication about all of their shared patients.

Ironically, but maybe not surprisingly, each group of professionals perceived that they initiated contact more frequently than their co-treaters. Psychiatrists described initiating the contact 52% of the time vs 22% for the therapists, with communication initiated simultaneously 25% of the time. In contrast, therapists perceived themselves as initiating contact 43% of the time vs only 2% for the psychiatrists with 56% initiated simultaneously. Although different populations of professionals were surveyed (ie,

PhDs, social workers, MDs), the disparity of results on contact initiation suggests that communication is valued by each group of professionals such that each perceived themselves as being the initiators. The survey results, however, suggest that estimates of contact are unreliable. There are no published studies in which neutral observers tabulate the number of contacts between psychiatrists and therapists.

The psychopharmacologist's perspective

The problems introduced by split treatment can best be understood by comparing the perspectives of psychopharmacologists and therapists. We base the examples given in this section on our numerous interactions with clinicians who have worked within these arrangements, as well as our own experiences with split treatment.

Psychopharmacologists usually complain most about the following issues when working with therapists:

- Some therapists demand excessive detail about ≥ 1 patients that is not immediately relevant to current treatment decisions. An active psychopharmacologist will have hundreds of ongoing cases, whereas a busy therapist may have a case register of 30 to 40 patients. Thus, each patient comprises a far larger part of the therapist's practice. Consequently, therapists may want to talk for a longer period of time about each patient. The therapist may want to describe details of the patient's past traumas, whereas the psychopharmacologist may want to know about recent changes in symptoms that necessitate alterations in the medication regimen.
- Some therapists suggest to patients that they should be taking a specific medication. One therapist frequently suggested to patients that "most of my clients do well on Zoloft" rather than suggesting that the patient discuss the general class of selective serotonin reuptake inhibitor (SSRI) antidepressants with the psychiatrist. Thus, the psychiatrist may feel that one of his or her central roles—working with the patient regarding available medical treatment options—has been usurped.
- Some therapists cannot be reached emergently (ie, do not carry a pager and have no answering service). Some routinely tell the patient to page the psychopharmacologist for all urgent situations, even those that are not pharmacologically related.

The therapist's perspective

Therapists may have an equal number of "gripes" regarding their interactions with psychopharmacologists:

- Some psychiatrists act as if the therapist is not an equal member of the treatment team, or that only the MD/prescriber is the "real doctor." This position is rarely spoken directly but may be implied by the physician's behavior toward the therapist. For example, some physicians assign menial tasks to the therapist, such as sending requests for prior medical records, contacting the patient's insurance company to obtain authorizations or clarify procedures, or calling the patient to urge him or her to make a follow-up pharmacology appointment.
- Lack of reciprocity when the therapist diligently conveys information to the prescriber but the latter either does not return phone calls or does not inform the therapist that a significant medication change was made during a recent visit. It is especially frustrating when therapists are not informed by the prescriber that the patient has been hospitalized for psychiatric care.
- The psychopharmacologist recommends a different form of therapy than the therapist is practicing with the patient, without prior discussion with the therapist. These disagreements can be compounded when the psychopharmacologist and therapist hold different opinions about what constitutes evidence-based practice.

Guidelines and recommendations for split treatment communication

When providing specific recommendations for split care, previous articles have focused on the frequency of interaction between the 2 professionals. The reality is that communication occurs less frequently than best-practice procedures would recommend.^{10,11} Sources of resistance to communication are probably multi-determined but must surely include time pressures (for both sets of professionals) and more subtle but important factors such as implied power relationships that may, for example, be expressed in the issue of who calls whom. Given the real time pressures on mental health professionals, the core guideline for communication should be for *optimal* frequency and detail, as opposed to simply *more* communication.

Mutual respect is vital. Without mutual respect, one of the providers may sabotage the working relationship. Patients are likely to perceive this lack of mutuality and splitting may occur. In our experience, good psychopharmacologist-therapist teams are usually borne of prior collaborative experiences, but also can occur *de novo*, such as in a clinical venue with assigned cases. Regardless of the venue, each clinician should be encouraging of the

other professional, even if one has no prior experience with that colleague.

At times, a specific therapeutic dyad simply does not work. Occasionally, incompatibility is due to rigidly held models of treatment, eg, a psychopharmacologist who feels that all forms of therapy are unhelpful or even countertherapeutic, or a therapist who feels that medications simply provide a bandage for psychological distress that should be treated with psychotherapy alone. Fortunately, these viewpoints are becoming less common.

When one's co-treater is acting in a manner that one thinks is incompetent or below the standard of practice. For example, one may be working with a therapist who frequently cancels the patient's pharmacotherapy sessions or with a psychopharmacologist who recommends outdated or ineffective medications. In the most egregious of these circumstances, it is appropriate to explain the dilemma to the patient, acknowledge the differences between the 2 professionals, and make clear that a change in personnel must occur to relieve the patient of being in the middle of an unworkable relationship. This situation is infrequent but does occur.

Communication should occur at important treatment junctures, such as when the following occur:

- A major change in diagnosis. For example, if one professional feels that the patient has switched from unipolar depression to bipolar disorder, this professional is likely to recommend changes in pharmacologic or psychotherapeutic strategy.
- A major change in symptoms, such as the emergence of psychosis or substance abuse. Minor clinical changes, such as a relative increase or decrease in the level of anxiety or depression, do not inherently necessitate contact between the 2 clinicians.
- New-onset or marked exacerbation of suicidal thinking or risk. In this context, questions of patient safety (eg, can the patient be kept safe in an outpatient setting?) must be addressed conjointly. For example, if the patient has a large quantity of medications at home, raising concerns about the potential to overdose, a coherent team strategy must be formulated. This may include having the therapist, who is likely to see the patient more frequently than the psychopharmacologist, keep the medication supply and distribute it one week at a time. It may be argued that this arrangement fosters excessive dependency on others for safety. Nonetheless, in a number of situations, there would simply be no comparable method to ensure patient safety related to overdose. Similarly, if the psycho-

pharmacologist has made a medication change, it would be vital for the therapist to communicate any change in clinical condition or significant side effects observed after that change (eg, a worsening of anxiety or significant agitation on SSRIs).

Some psychopharmacologist/therapist dyads talk regularly about all their shared cases. We believe this strategy is commendable and probably more efficient when there are multiple cases in the context of a strong professional relationship.

Case 1

Tashia: Inadequate communication between mental health professionals during the emergence of an antidepressant-induced manic episode.

Tashia was a 31-year-old woman with a history of depression treated with psychotherapy alone. She had no prior manic or hypomanic episodes, although her maternal uncle had bipolar I disorder. She had been in psychotherapy for 1 year with Ms. Samuels, a therapist with a master's degree, primarily working on issues related to her romantic relationships. At the onset of her current depression, which was of moderate severity, Tashia went to a psychopharmacologist (Dr. Mathews) whom she found on a list of her in-network providers. Ms. Samuels and Dr. Mathews did not know each other, and neither made any attempt to communicate with each other. After a sertraline trial was ineffective, unbeknownst to Ms. Samuels, Dr. Mathews switched antidepressants and prescribed venlafaxine. Two weeks after starting venlafaxine, Tashia felt much better but exhibited out-of-character hypersexuality and equally atypical spending. Ms. Samuels noticed these changes but attributed them to Tashia's enormous relief at feeling better. By the time Ms. Samuels called Dr. Mathews, the patient had been taking venlafaxine for 1 month, had done damage to her primary relationship, and was deeply in debt. When Dr. Mathews finally recommended hospitalization for Tashia, he also suggested that she "get some therapy." Ms. Samuels only found out about the hospitalization *after* Tashia had been discharged. Still, no contact between the professionals occurred.

Case 2

Nathan: Suicidal ideation curtailed by a good working relationship between mental health professionals.

Nathan, age 46, was being treated for long-term marital difficulties and recent-onset depression that seemed to

be steadily worsening. He was in weekly therapy with a clinical psychologist, Dr. Lassiter. When the depression worsened, Dr. Lassiter referred him to Dr. Fogelman, a psychiatrist with whom he had shared cases before. A few weeks after starting an antidepressant and a low dose of lorazepam, Nathan's depression continued to worsen with new-onset suicidal ideation, manifested by an increased preoccupation about overdosing. Alarmed by the worsening of his client's depression, Dr. Lassiter contacted Dr. Fogelman. Together, they decided—with Nathan's agreement—that Dr. Lassiter would keep Nathan's medications and dispense 1 week of tablets at a time until his suicidal ideation improved sufficiently. Six weeks later, with more psychotherapy and the addition of an adjunctive antidepressant, Nathan's suicidal ideation had markedly diminished. In a conference call, all 3 parties agreed that Nathan could keep his monthly supply of medication at home.

We see value in longitudinal research that tracks the naturalistically occurring contacts between psychiatrists and therapists, in which both quantitative (eg, contact frequency) and qualitative variables (eg, mutual trust, power imbalances, understanding of each others' treatment objectives) are measured from the perspective of clinicians, administrators, and observers. Eventually, the costs of different treatment arrangements compared with their long-term benefits to patients will be calculable. Despite our current lack of data, some reasonable guidelines, such as those suggested here, can help clinicians make split treatment as effective as possible to avoid therapeutic splitting and increase the potency of each treatment component. ■

CONCLUSIONS

Given the dominance of split treatment arrangements in outpatient settings, it is surprising how little research on its cost-effectiveness has been conducted. Even with the advent of electronic health records, the issues raised here will continue to affect clinical treatment. Simply reading the chart notes of a co-treater cannot take the place of direct communication. Split treatment will be increasingly common in the next era of health care, when more patients are treated in "medical homes" by psychiatrists, therapists, and general practitioners. Given this likelihood, it will be increasingly important to evaluate the cost-effectiveness of split treatment across a variety of disorders, as well as across pairings of clinicians with different degrees, theoretical orientations, or levels of experience. Clinical trials comparing randomly assigned groups that vary on these attributes will certainly be informative but also quite costly to conduct.

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