“THE ‘MED CHECK VISIT’: IS PSYCHIATRY BECOMING AN ENDANGERED SPECIES?”

Bernadette Grosjean MD. Assistant Clinical Professor. Harbor UCLA.
Grand Round March 6, 2012
Evolution of Psychiatric “Care”
In the last 50 years (USA):
- number of Psychiatric beds went from 500,000 to <40,000
- Average length of stay: 421 days to 4.8 days

Between 1986 and 2008 there was a 48-fold increase in money spent on antidepressants and antipsychotic drugs ($24 billion in 2008)

Americans with Diagnosis of schizophrenia went from 1/617 (1955) to 1/125 (2010)
Experts estimate a need for a minimum of 50 public psychiatric hospital beds for every 100,000 people. This number is contingent upon the availability of appropriate outpatient services in the community.

U. S capacity for inpatient psychiatric services has declined dramatically since 1965, from approximately 500,000 (340/100,000) to less than 50,000 in 2005 (17/100,000).

Since 1995, California alone has lost 40 psychiatric wards or hospitals, representing nearly a 22% drop.

In 2010, California had 17 psychiatric inpatient beds for every 100,000 residents. length of stay has gone from 421 to 4 or 5 days in the last few decades. In this context, “hospital treatment" can be considered an oxymoron.
“Med Check”
“Most psychiatrists are too busy for our own good”.

(...)

Reclaiming your power during medication appointments with your psychiatrist

National Empowerment Center 2011 Patricia Deegan, Ph.D.
15’ is the new 45’

Jon (Graduated in 2009)

- “Our med eval appointments are 30 minutes (...) follow up are 15 min. About the 15 min med check...it is absolutely NOT ideal, but it is becoming the standard of care for managed care mental health”.

- “In my private practice, (where patients pay cash), I see patients for a minimum of 30 min and my initial evaluations last up to 90 minutes. If I accepted insurance, the maximum reimbursement I could get would not allow me to see patients for longer than 15 minutes and maintain financial stability in my practice. This is also why I have a "regular" job, and keep my private practice small”
Questionable assumptions of “15’ med check”

- Medication without any acknowledged form of (and time for) therapeutic engagement is good psychiatric care

- “Mind and brain” are separate and require (and/or can benefit from) different treatments given separately

(Good bye the bio-psycho-social-cultural-spiritual model)
Paradoxes
The Procrustean Approaches
Paradox 1

- Time given to physician is inversely proportional to the number of diagnoses they have to consider.
—“So what would you say was the value of the diagnosis?”
—“I got paid.”

- Greenberg G. Inside the battle to define mental illness. Wired, Dec 27, 2010.
Paradox 2

- More and more diagnoses…but less and less options about the type of intervention/treatment psychiatrists can offer to their patients
“Psychiatry, for me and many of my colleagues, had become a process of corralling patients’ symptoms into labels and finding a drug to match”.

- D Carlat MD Mind over meds NY Times 2010

“I am giving a pill to heal a broken heart”

- Dora Wang The Kitchen Shrink 2010
Paradox 3

“Drugs don’t work in patients who don’t take them!”

— Former US Surgeon General C. Everett Koop
(some) reasons for non adherence
(Dr Alphonso Psychiatric Times 2011)

- Poor insight/ negative attitude toward medication/denial of illness...

- Therapeutic alliance factors
  - Feeling disrespected /infantilized
  - Feeling coerced/manipulated
  - Failure of empathy

(...)
Paradox 4:
“Med check” and Neurosciences
“From the perspective of neuroscience, psychotherapy can be understood as a specific kind of enriched environment designed to enhance the growth of neurons and the integration of neural networks”

*The Neuroscience of Psychotherapy*

Cozolino, 2010.
In contrast to the prevailing privileged status of verbal, conscious cognition, it is more and more evident that **emotional communications** between therapist and patient lie at the psychobiological core of the therapeutic alliance (Schore, 1994, 2011).
Paradox 5

- Psychiatrists are used more and more as “consultants” to the most complex “cases”

- …but they get less time per appointment and fewer appointments per year than any of their coworkers
Paradox 6: “Experience” versus “Deliberate Practice”

The 20,000 hour/10 years rule…

Deliberate Practice and Acquisition of Expert Performance: A General Overview

K.A.Ericsson  Academic Emergency Medicine 2008
“Research across domains shows that it is only by working at what you can’t do that you turn into the expert you want to become”

Paradox 7: from “divine right of leadership*” to “drug dealer”

- Risk of still being an outsider
- Issue of accountability without authority

*Alan Rosen Current Psychiatry 2006
Conclusion
There is no such thing as a “Med Check”

Could we conceive something like “a good enough med check?”
“You can't stop the waves, but you can learn to surf”

Jon Kabat-Zinn.
“When I ask someone what I’ve done that helped them recover the most, they rarely respond that it was that clever combination of Paxil, Depakote, and Risperidone. They usually point to some moment of human kindness and connection (...)

Mark Ragins MD. Building a Recovery Based Psychiatric Practice: Setting Priorities for Limited Resources 2011
Back to basics
Traditional Principles
(e.g., Treatment of Chronic Illness)

**Time**  
*Healing takes time and time is healing*

**Relationship**  
*Healing takes place within the context of a relationship.*

**Intensity**  
*Achieving an energy of activation is necessary*

**Holism**  
*Mental/emotional/physical*

**Peace and Quiet**  
*The distractions of modern life "inactivate" catalysts for change*

**Self-awareness**  
*Self-reflection needed for healing*

**Rest**  
*Change often requires a break in usual daily rhythms.*

**Ceremony**  
*To access spiritual aid to healing*

(From: **Lewis Mehl-Madrona, M.D., Ph.D.** Traditional (Native American) Indian Medicine  
[http://www.healing-arts.org/mehl-madrona/mmtraditionalpaper.htm](http://www.healing-arts.org/mehl-madrona/mmtraditionalpaper.htm))
As an clinician...

Even in 15min, take the time...even so brief...

- to really “be with” our patient
- to be able to genuinely listen
- to be ready and able to explore as/if needed
- to make our patient feel that we believe in what we are doing, that we are working together and that we recognize the power and the role they (and their environment) have in their own recovery
- to take care of our own mental health
As an expert

- Let’s deserve it
- Let’s design it or at least participate in that design
As a profession

- Move away from misuse of DSM Diagnoses and return to basic phenomenology
- Reemphasize the significance of the relational even for a “med consult”
- Pursue deliberate practice (and claim the time to do it properly)
- Be a role model for our students (and patients) by showing how to adapt to the inevitable changes in systems while maintaining basic ethical and clinical standards (even if it means “lowering financial expectations”)
As a Professional Organization

- Rehabilitate the reputation of psychiatrists as caring and trustworthy professionals healers

- Demand respect for our expertise and the necessary conditions to practice our “art” in a way that will help patients in the short AND long term
Thank you

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