A discussion about mental health care, access and patient safety

Tamara Campbell, MD, PsyD, *has more than thirty years of experience in the field of mental health. She began her career in mental health as a psychiatric social worker and later attained her Doctorate Degree in Clinical Psychology. Following a twelve-year career as a clinical psychologist which included service in the United State Airforce and the Department of Defense, she entered medical school at the Boonshoft School of Medicine, Wright State University. She completed Internship and Residency in General Psychiatry at the University of Cincinnati, College of Medicine, where she served as Chief Resident. Dr. Campbell is currently the Associate Chief of Staff for Education at the Veterans Affairs Medical Center in Cincinnati and she maintains a private practice at the Center for Psychotherapy and Psychoanalysis. Dr. Campbell is President of the Ohio Psychiatric Physicians Association and a Fellow of the American Psychiatric Association.*

"You're talking about lives here. When people come to doctors, they trust us. They trust us to know what we're doing and to do right by them. Patients trust that we're going to deliver the best care to them and not do any harm. 'Do no harm' goes by the wayside when you're not adequately educated and trained."

– Dr. Tamara Campbell

Q **How important is it to have a team of providers in a collaborative care model?**

A It is very important, and I know firsthand because during the course of my career I have been part of the collaboration in different roles. I started as a community mental health social worker and case manager working alongside a psychiatrist and a psychologist. It was a positive relationship and my first close collaboration with medicine and psychiatry. Without my assessment as a social worker, the psychiatrist would not have the information necessary to understand all the dynamics of the patient. I assisted the psychiatrists in making decisions about medical care and community re-entry. At that time the country was deinstitutionalizing patients so more treatment was completed in the community. It was imperative for the community mental health centers to have a tight collaborative effort to make sure the patient remained stable, out of the hospital, and integrated in the community.

Q **How important was your medical training?**

A It was critical because once I started medical school, I realized I didn't know, what I didn't know! As a psychologist, I was an integral part of the team. I provided experience in behavior science, in therapy, and in psychological testing – they needed that in significant ways. However, the medical intervention necessary to prescribe medications and to deal with urgent and very seriously ill patients was at a different level. I think that was the first time I really understood the differences in the skill set and the need to have both collaborative efforts there in different ways.

Q **How is the training different between psychologist and psychiatrists? Why is it important?**

A That is important because of the mission for each profession. Psychologists provide behavioral health services and are experts in psychotherapies and the various psychological testing assessments. Psychiatrists are educated first as physicians; we understand medicine and all the body's systems. We then complete four years of residency, the first year's training being all about medicine in general, with an extensive focus on internal medicine and emergency medicine. We complete rotations specifically in psychiatric emergency service. So you have to have that very in-depth medical background because the first thing you do in psychiatry is rule out medical issues that could be presenting like psychiatric issues. If you don't do that, you could be going down the wrong path in terms of diagnosing and treatment.

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Q **Why is the proposal to give psychologist prescriptive authority a bad idea?**

A The proposal from our psychology colleagues (HB 326) is a very different proposal than the proposal presented in the legislature 20 years ago. When psychologists began seeking prescriptive authority, the training they proposed was much more in depth. For example, the Department of Defense pilot program, which they've since abolished, was a two or three-year program. Now it is 425 hours of online course work. That just doesn't make sense, nor is it responsible. I would imagine that my psychology colleagues would be concerned about safety, especially given the amount of time they spend earning their doctorate degree. We need to take a step back and think about all the medical training and experience necessary to prescribe prescription drugs and how a proposal only requiring 425 online hours of coursework might impact patient outcomes and safety.

Q **How could this proposal impact patient outcomes?**

A I am concerned about negative outcomes because it's not just about coursework; it's about clinical experience with supervision. In psychiatry in the first year, students are educated about the backbone of medicine which is internal medicine, family medicine, neurology, all under supervision. Considering that 65-70 percent of our patients have co-morbid medical conditions, we must have the education and training to know what to do for a patient's total health history. I still have times with patients when I am unsure about the pathology or treatment and I need to consult medical colleagues. And when you're talking about tapering a medication or adjusting it to a therapeutic dose, that takes a lot of understanding of drug interactions. You can easily do something that is not helpful, but harmful to the patient.

Q **What about the concerns over access to mental health services in Ohio, and not enough prescribers?**

A Access is a concern. And we already have the means to increase the number of prescribers in Ohio. My way was to go to medical school, but I know not everyone has the time or resources to do that. For medical professionals who want to prescribe, medical school is the ideal path to become a safe prescriber, in my opinion. In Ohio, Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) have a solid breadth of knowledge in medicine that is needed to safely prescribe. For APRNs and PAs who choose to get the extra training to prescribe, this is working and helping to boost access. Psychologists who want to prescribe can do so by completing biomedical education and training, which is required of a psychiatric APRN or PA, in addition to the psychopharmacology prescribing education. There must be a foundation of medical knowledge prior to completing any type of psychopharmacology degree program. In addition, we must continue to increase collaboration with our primary care physicians through telehealth/telepsychiatry opportunities. Also, psychiatric APRNs can now enter into a collaborative agreement with primary care physicians, which will be especially helpful in rural areas, I believe all of these efforts are safer avenues to address access issues. The collaboration of physicians, nurse practitioners, psychologists, social workers and licensed professional counselors remains essential.

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