It Takes A Village: Collaborating to facilitate youth client/family recovery

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Author: Becoming You, Fast facts Loving your research project, Fast Facts Managing a Patient with psychiatric disorder, and Fast Facts Substance Use Disorders

Dr. Marshall has no conflicts to disclose.

WILLIAM PATERSON UNIVERSITY

Case Study

- 14 y.o. male, “Pat”, thin, quiet, nervous. Only child.
- Childhood medical history of “floppy esophagus”.
- Multiple ED trips as a baby/young child.
- “Exceptional” child – very intelligent
- Presents with anxiety, multiple ritualistic behaviors, described as “quirky” by parents.
- Being treated by herbalist and chiropractor.

Reason for 1st visit

- Middle school end of year trip to Washington DC, Chief complaint: Pat has some ritualistic behaviors around eating, cannot swallow pills.
- Parents would like behavioral intervention to teach the child how to swallow pills and perhaps try some new foods.
- Client would like to be able to go to the Washington DC end of year trip without having to have parents come, or to have special considerations made to him.

Therapeutic Intervention

- Behavioral techniques used to change some of the rituals around eating.
- CBT to challenge beliefs related to ability to try new things.
- Sensorimotor psychotherapy to examine character strategies related to trauma of choking and multiple ED visits as a young child.

OUTCOME after 6 months of therapy

- Family Dynamics changed
- Increased insight into behaviors around eating
- Increased ability to try new things
- Capacity to swallow pills
- Changed schools for High School

- Went on trip to Washington with any special considerations.
- Psychiatric referral for follow up suggested. Parents ask for names of neurologists and psychiatrists.

Second Round

- Reason for visit:
  - Unable to complete homework assignments.

- 14.5 years old, thin, very immature looking, hesitance in speech patterns, increased "quirkiness", hypomanic in movements during interview with flight of ideas and wringing of hands. Denies hearing voices or any visual hallucinations, however appears to intermittently stare off into space. Personal hygiene declined, dirty hair, unkempt and dirty teeth.

Challenges

- Parents are very nervous about seeing a psychiatrist. DO NOT want their child medicated.
- Parents have been changing the herbalist's medications and feel that the herbalist can deal with the problem.
- Client unable to speak at sometimes, appears to be in extreme emotional distress. Not sleeping at night, unable to go to school, sometimes unable to talk.

Meeting with Parents and Client

- Client is extreme distress, anguished with guilt and self-loathing.
- Reveals that he has both visual and auditory hallucinations, but afraid of them and afraid to tell anyone.
- Parents attend session, client reveals the truth.
- Parents accept need for psychiatric referral, identify and contact Dr. Nanci Lebowitz- Naegeli.

Initial meeting with Dr. N

- Highly anxious
- Obsessive/compulsive thoughts and behaviors
- Intrusive thoughts vs. psychosis?
- Insomnia
- Socially awkward
- *decrease in academic functioning
- over-involvement of parents

Medication Challenges

- Parents and patient mistrustful of medication and psychiatrists
  - Endorsement from primary clinician is key
  - Team approach with clinician and family
  - Evidence/scientific approach
- Patient slow to warm-up
  - Collaboration is key to getting accurate information
- Atypical presentation
- Atypical response

Summer Suicide note

- E-mail of suicide note to Dr. Marshall
- Face time with family
- Hospitalization

COLLABORATING ACROSS DISCIPLINES

Collaboration on Pat

Dr. Marshall

- Initial trust factor with Dr. Marshall allowed the family time to get used to the fact that the child has a mental illness.
- Dr. Marshall does not medicate any patient under 21 years of age.
- Collaboration between Dr. M and Dr. N increased family's ability to express worries and make best use of visits to each provider.

Dr. N

- Parents identified Dr. N and had excellent references for her that they trusted.
- Emphasis on team approach and communication

Differences in Approach to Care

Nursing

- 2-4 years of general nursing education (DIP/AD/BSN)
- 2-6 years advanced nursing specialist education (NP/ DNP)
- 5-9 years Scholarly/Academic nursing education (EdD, PhD,)

Medicine

- 4 years pre-med
- 4 years medical school
- 3-4 years residency
- 2+ years fellowship

Similarities in Approach to Care

- Professionalism
  - Patient safety
  - High standard of care
- Experience in the medical model
  - Hospital-based education
  - Familiarity with labs
  - Familiarity with medication
  - Evidenced-based approach
- Desire for good outcome!

Boundaries and Collaborations

- Respect for each other's knowledge and skills should not create boundaries that challenge authority, but rather support responsible provision of comprehensive care.
- Do you see what I see? 2 different disciplines with 2 cognitive maps
  - Cognitive Learning Theory: professions attract people with specific sets of learning styles and skills. This promotes homogeneity in views and culture within any profession.
    - MD's highly competitive academic environment. Solo practice, independent decision making. 1:1 with patient
    - Nurses work in teams, collective problem solving. Collaborative exchange of info for continuity of care across shifts. Family approach

Values

- MD education – take charge, assume the leadership role in multiple settings.
  - Totally responsible for outcomes of decisions.
  - Focused on Action and Outcome – rather than developing relationships
  - Historically Authoritarian relationships with patients
  - Rely on objective data
- Nursing education – Collaboration, sharing of information for comprehensive patient care
  - Shared decision making
  - Focus on relationship and respect for patient story and beliefs.
  - Relies on both hard and soft data.

CLINICAL EDUCATION

- In most systems, neither MD nor RN/NP are educated to interact collaboratively with other health care students/providers from different disciplines.
- Professors/clinical faculty rarely collaborate with other professionals as role models.

Keys to Successful Collaboration

- Profession-specific roles, but analysis of problems, goal identification and responsibilities for actions are determined as a team.
- Be aware of overlapping competencies and identify them as the ability to see the same problem from multiple lenses.
- Learn each other's language.
- Respect for each other's expertise

Skills needed for collaboration

- Cooperation
- Assertiveness
- Responsibility
- Communication
- Autonomy
- Coordination
- Respect

BACK TO PAT

- Current team:
  - Client
  - Parents
  - School
- Medical
  - B. Marshall
  - N. Lebowitz-Naegeli
  - Hospital staff
  - Outpatient staff
  - Chiropractor/herbalists

Care Coordination

Dr. Marshall

- Client psychotherapy
  - Weekly sessions and
  - PRN
- Parent communication
  - Weekly and PRN

Dr. Lebowitz-Naegeli

- Hospitalizations and IOP
- Medication Management q 1- 3 months and PRN
- Coordination of communication with schools.

CLIENT OUTCOMES

- Medication Adherence
- Academic Achievement
- Increased Independence
- Social Skills
- Increased Insight

OUR OUTCOMES

- Increased collaboration across other clients
- Increased ability to recognize each other's strengths
- Increased capacity to provide excellent, comprehensive care to our clients. Improved outcomes
- Mutual learning/provide sounding board (2 heads better than 1)
- Sharing the responsibility and load of difficult cases (We do difficult work!)

Questions?

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