

Primary Care Consultation Psychiatry

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Primary Care Consultation Psychiatry

This series of five modules is designed to introduce a psychiatrist to the practice of primary care psychiatry. There is a special focus on the developing role of a psychiatrist functioning as part of a collaborative care team. Each module has stated objectives and a content slide set. The core topics are:

- Module 1: Introduction to Primary Care Consultation Psychiatry
- Module 2: Building a collaborative Care Team
- Module 3: Psychiatric Consulting in Primary Care
- Module 4: Behavioral Interventions and Referrals in Primary Care
- Module 5: Medical Patients with Psychiatric Illness

Module 5: Medical Patients with Psychiatric Illness

Learning Objectives: Module 5

By the end of this module, the participant will be able to:

- Describe the principles of chronic illness care and how they apply to behavioral health.
- Identify common medical co-morbidities and provide treatment recommendations that take these into consideration.
- Integrate chronic pain and pain management strategies into treatment plans for behavioral health.
- Discuss behavioral health approaches to special populations.

Role of Primary Care Psychiatrist

- **Help team assess 'medical' causes and contributions to common mental health problems**
- **Help adapt behavioral interventions to patients' medical conditions**
 - **Medical illnesses**
 - **Special populations (e.g., pregnancy, older adults)**

Principles of Chronic Care = Principles of Integrated Care

Patient Centered Care

- Team-based care: effective collaboration between PCPs and Behavioral Health Providers.

Population-Based Care

- Proactive, planned contact rather than acute care
- Registry: no one 'falls through the cracks'.

Measurement-Based Treatment to Target

- Measurable treatment goals clearly defined and tracked for each patient
- Treatments are actively changed until the clinical goals are achieved

Evidence-Based Care

- Treatments used are 'evidence-based'.

Integrated Care for Diverse Populations

Chronic Pain

- Depression and chronic pain

Common Medical Disorders

- Depression, heart disease, diabetes

Maternal Behavioral Health

- Depression in the peripartum period

Geriatric Behavioral Health

- Depression and Dementia in the elderly

Chronic Pain



Chronic Pain

20 – 30% of younger and 60 – 80% of older adults report pain on a daily basis

Chronic pain involves:

- Suffering: physical and emotional**
- Disability, activity & work limitations**
- Lower quality of life**

15% of those with chronic pain say they cannot work because of it

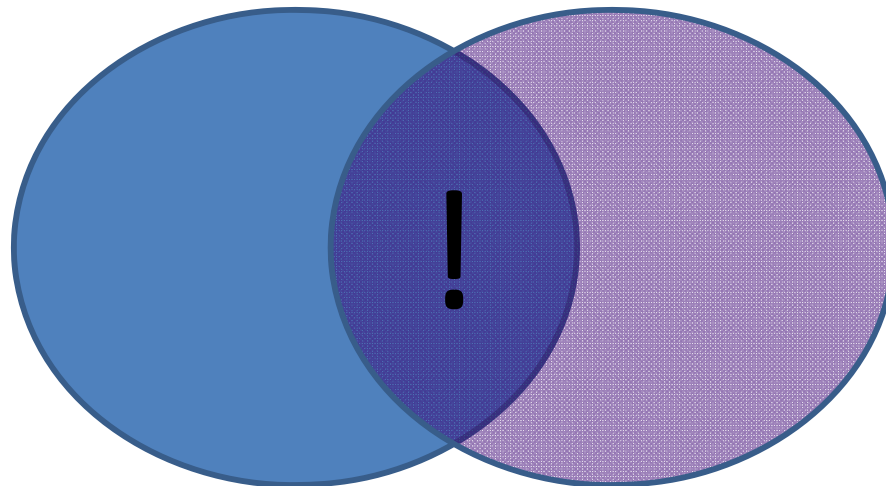
Pain  Depression

Bidirectional Relationship

Depression and Pain Have Combined Effects

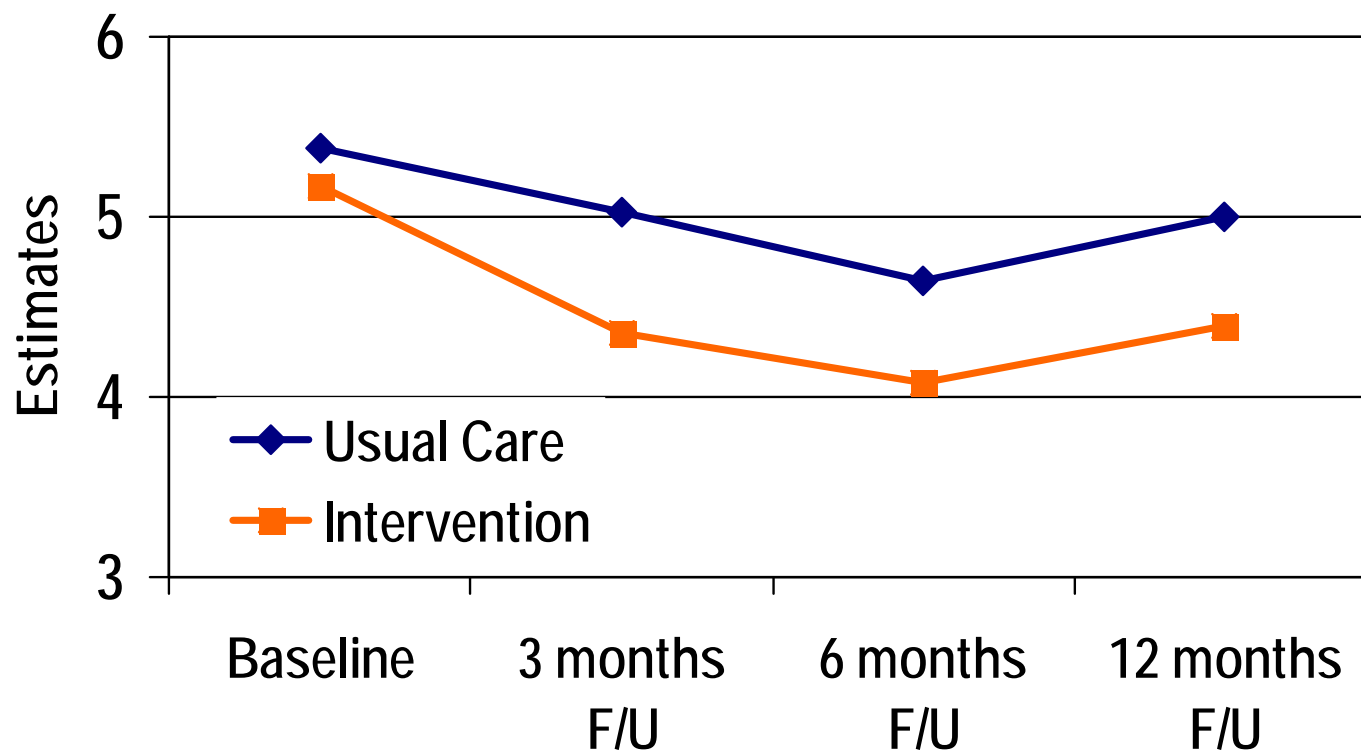
Depression with pain causes more functional limitations and economic burden than depression alone

Pain with depression predicts greater functional impairment than pain alone

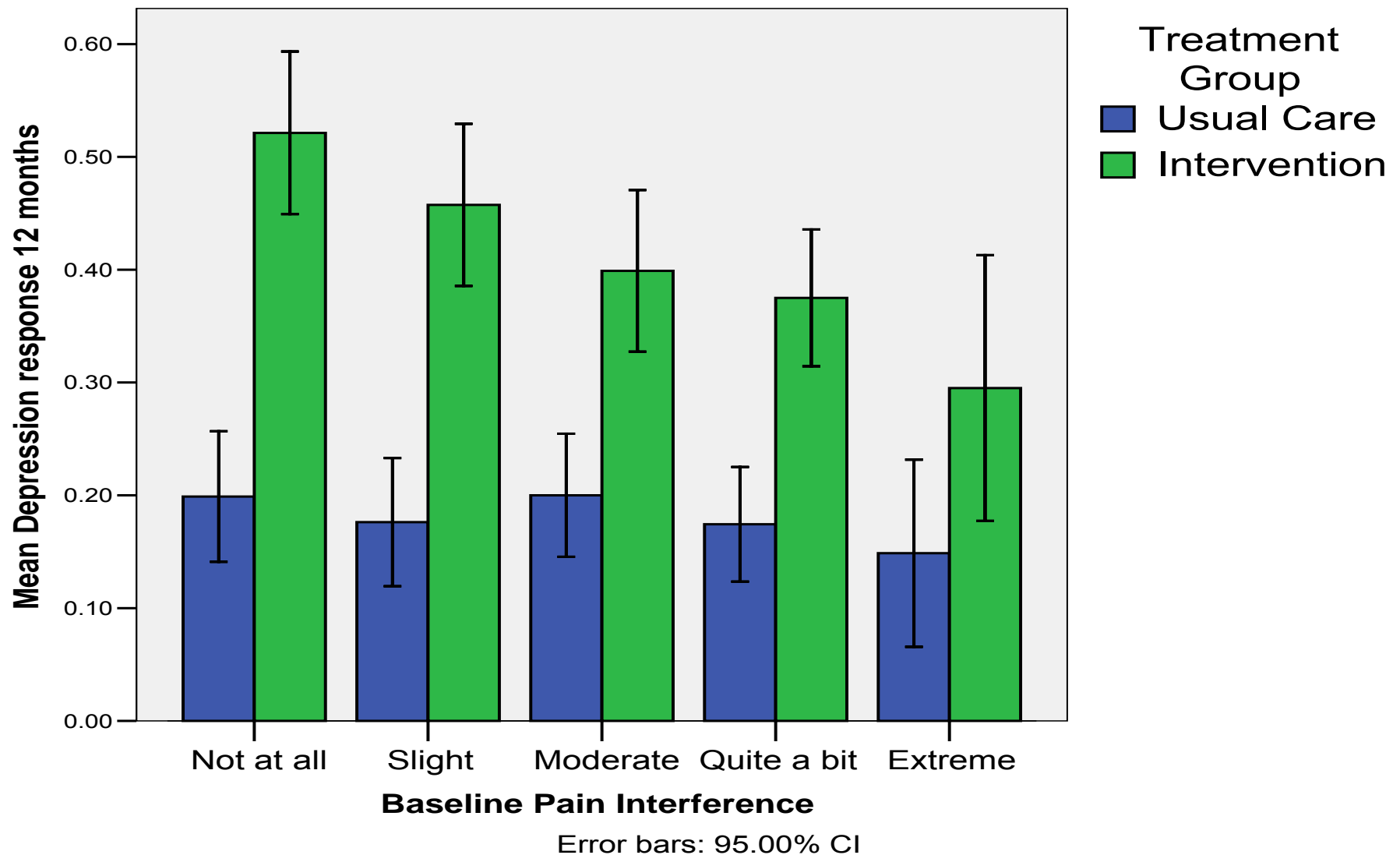


Treatment of Depression Improves Pain Outcomes in Patients with Arthritis and Depression

Arthritis Interference With Daily Activities (0-10)



But: Pain Impedes Improvements in Depression



Thielke SM et al (2007) Am J Geriatr Psychiatry 15(8):699-707.

Managing Persistent Pain

Establish a diagnosis

Educate patient

- All pain is ‘real’

Focus on functional impairment

- What does the pain keep you from doing?
- How do you cope with this?

Encourage

- Regular physical activity
- Adequate trials of analgesic medications
 - *“How bad does the pain need to be?”*

Consult

- Orthopedics, Rheumatology, PT/OT

Coordinate care with all providers

Stepped Care

Systematic outcomes tracking

- Patient Health Questionnaire (PHQ-9)
- Brief Pain Inventory

Treatment adjustment as needed

- Based on clinical outcomes
- According to evidence-based algorithm
- In consultation with psychiatrist and PCP

Integrated Care Treatment Protocol

- 1) Education**
- 2) Behavioral Activation / Pleasant events scheduling**
- 3) a) Antidepressant medication**
Usually an SNRI or other newer antidepressant
- b) Analgesic medications**
Acetaminophen, NSAIDs, opioids
- c) Other**
Gabapentin for neuropathic pain
- 4) Brief, problem-focused psychotherapy**
(CBT or PST-PC) 6 to 10 sessions

Pain Medications

- **Acetaminophen**
- **Non-steroidal anti-inflammatory drugs (NSAIDs)**
 - **Aspirin, NSAIDs**
- **Antidepressants**
- **Opioids**
- **Adjuvant medications**
 - **Anticonvulsants**
 - **Stimulants**
 - **Antidepressants**

How to Use Pain Medications

- **Use / change one drug at a time**
- **Careful with total daily dose**
 - **Acetaminophen or ibuprofen may be taken OTC but also contained in many prescription drugs**
- **Start low but go to target doses**
- **Give adequate trial**
- **Scheduled rather than PRN (“as needed”) dosing. Take medications before pain gets bad.**
- **Manage side effects**
- **Change treatment if no effect after 10 to 14 days at target dose**
- **Combine medications and other treatments if only partial response**

Referral to Physical Therapy

Assess current activity level, gait, strength, fitness, preferences

Create individualized physical activity plans

- Preserve or restore range of motion / flexibility
- Increase aerobic conditioning
- Increase muscle strength / endurance
- Include physical activities into daily life

Be aware of physical deconditioning

- Gradual increase in frequency and intensity (pacing)

Pay attention to rewards and positive reinforcers

Address fears and concerns about physical activity

Osteoarthritis

- Non weight-bearing/Low impact exercise: walking, warm-water pool exercise

Other Treatments to Consider

Relaxation / Meditation / Guided Imagery

Electrical counter-stimulation (TENS)

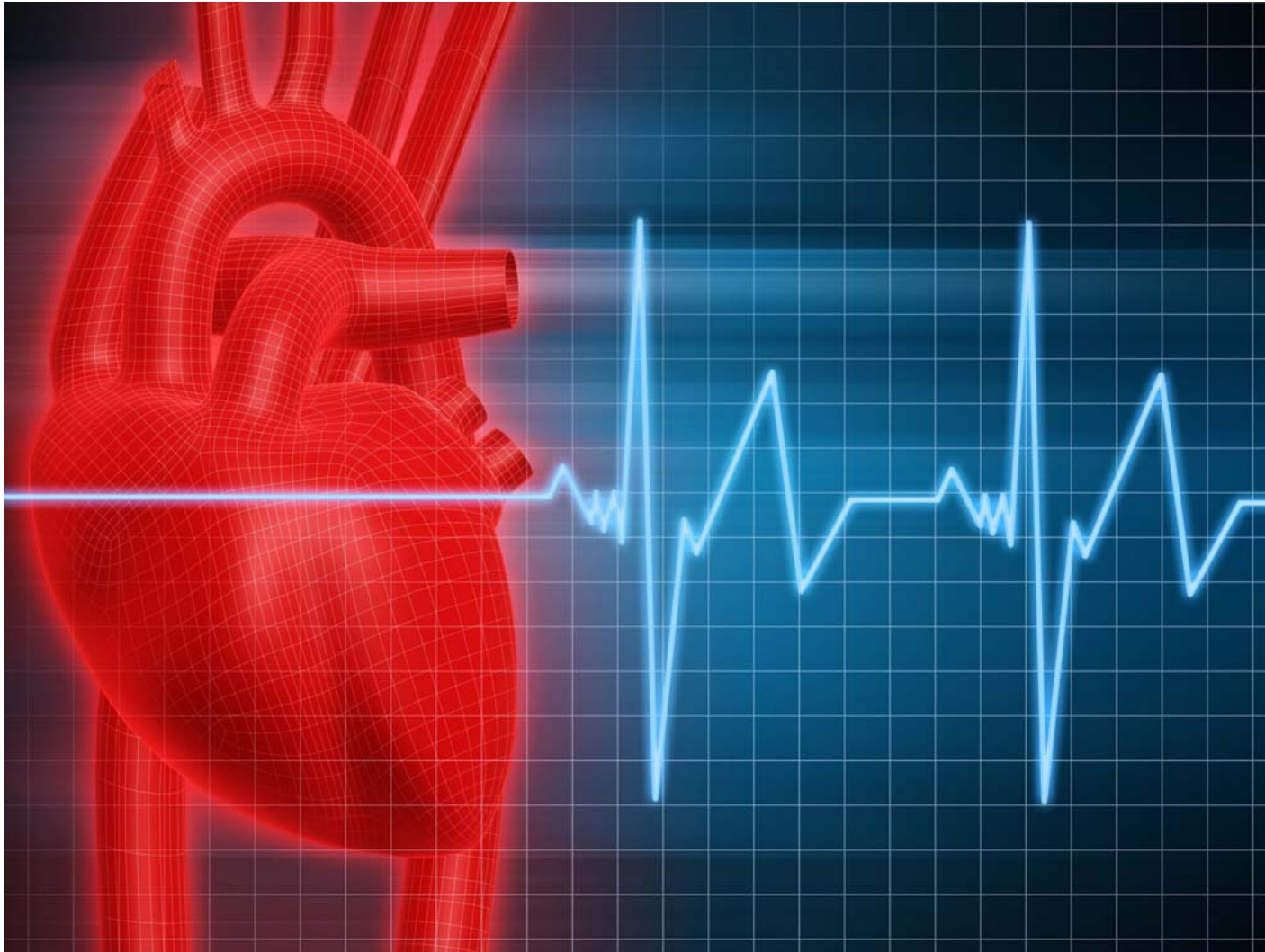
Acupuncture

Nerve blocks or infiltrations

Neurosurgical procedures

Orthopedic (e.g., hip, knee, or shoulder replacement)

Medical Co-Morbidity



Poor Adherence and Self-Care

↓ Adherence to Medications

- Oral hypoglycemics
- Anti-hypertensives
- Lipid lowering

↓ Self-care

- More obesity, smoking
- Less exercise and healthy eating

Major barrier for effective medical care

Lin et al, Depression and Self Care Diabetes Care, Diabetes Care 2005.

Depression and Co-Morbid Medical Illness

- ↑ **Disability / Quality of Life**
- ↑ **Complications (↑ HbA1c)**
- ↑ **Mortality (CAD)**
- ↑ **Medical Cost (~ 50 % increase)**

*Wells, 1988, Von Korff 1999, Carney, 1998, DeGroot, 2001,
Lustman, 2000, Frasure-Smith, 1999*

Depression Increases Odds of Complications and Mortality

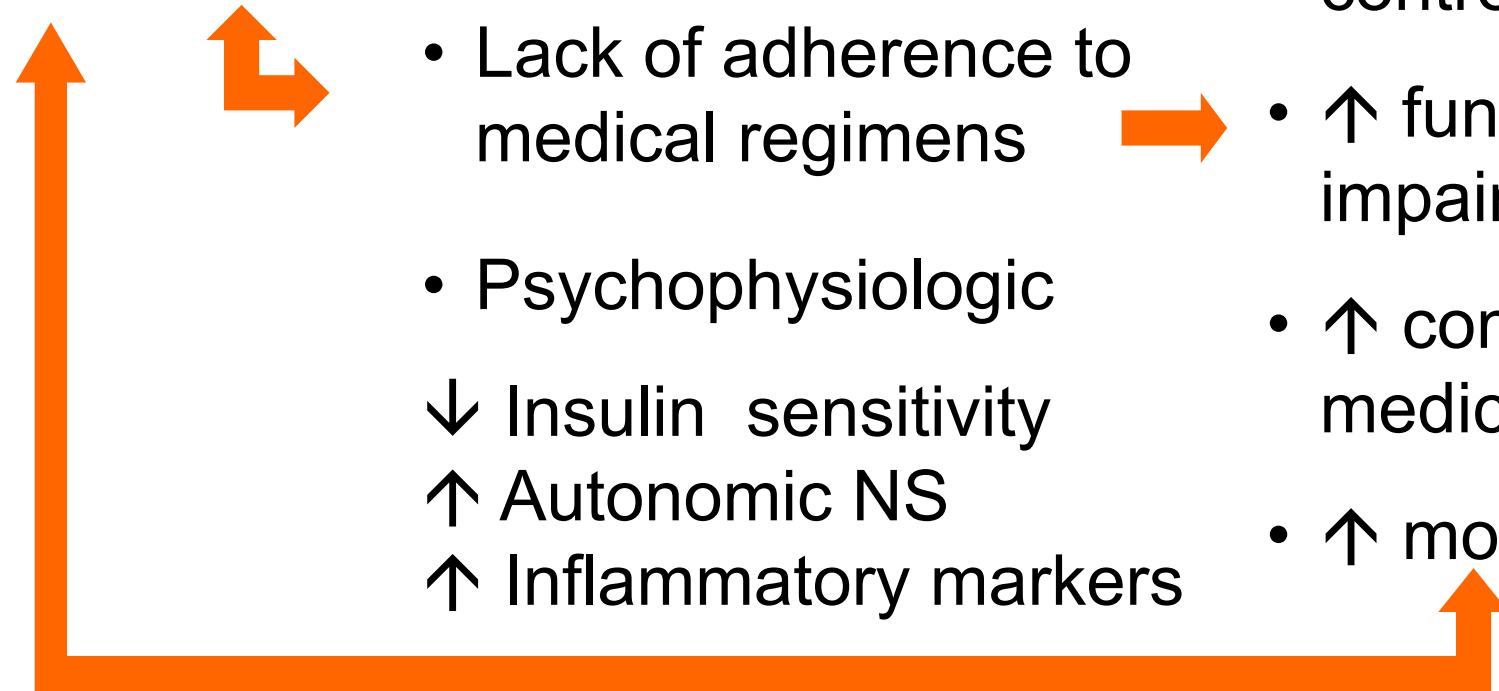
	Major Depression
Microvascular Complications	1.33 (1.08, 1.65)
Macrovascular Complications	1.38 (1.08, 1.78)
Mortality (All cause)	1.53 (1.19, 1.96)
Foot Ulcers	1.99 (1.22, 3.24)
Dementia	2.69 (1.77, 4.07)

Depression and Heart Disease/Diabetes: Adverse Bidirectional Interaction

Major Depression

- Smoking
- Sedentary lifestyle
- Obesity
- Lack of adherence to medical regimens
- Psychophysiologic
 - ↓ Insulin sensitivity
 - ↑ Autonomic NS
 - ↑ Inflammatory markers

- Medical illness at earlier age
- Poor symptom control
- ↑ functional impairment
- ↑ complications of medical illness
- ↑ mortality



Depression, Diabetes, and Heart Disease

Pathways and Teamcare Studies Wayne Katon, MD¹ & Colleagues²

¹ *University of Washington School of Medicine*

² *Group Health Research Institute*

NIMH Grants MH 4-1739 and MH 01643 (Dr. Katon)

NIMH-Funded Team Care Study

Diabetes or CAD

- Evidence via automated date (ICD-9) of having diabetes and/or coronary artery disease (CAD)

Hypertension

- Evidence of poor disease control ($\text{HbA}_{1c} \geq 8.5$, blood pressure $>140/90$, LDL >130)

Depression

- PHQ-9 ≥ 10

TeamCare Intervention Goals

Improve depression care:

Behavioral activation and antidepressants

Improve medical disease control:

HbA_{1c}, HTN, LDL

Improve self-care:

Diet, exercise, cessation of smoking, glucose checks

Key Components of TEAMcare

Primary Care Physician

Nurse care manager

Physician caseload supervision

**Registry to track key outcomes (HbA_{1c},
SBP, LDL, PHQ-9)**

TREAT-to-TARGET stepped care

Key Components of TEAMcare

Depression Initial Target

Behavioral activation

Antidepressant medication



Medical Disease Control: TREAT-to-TARGET Guideline
(PCPs approve Care Manager increasing insulin or blood pressure medications)

Adherence?

Optimal dosage?

New medication?

Behavioral Goals

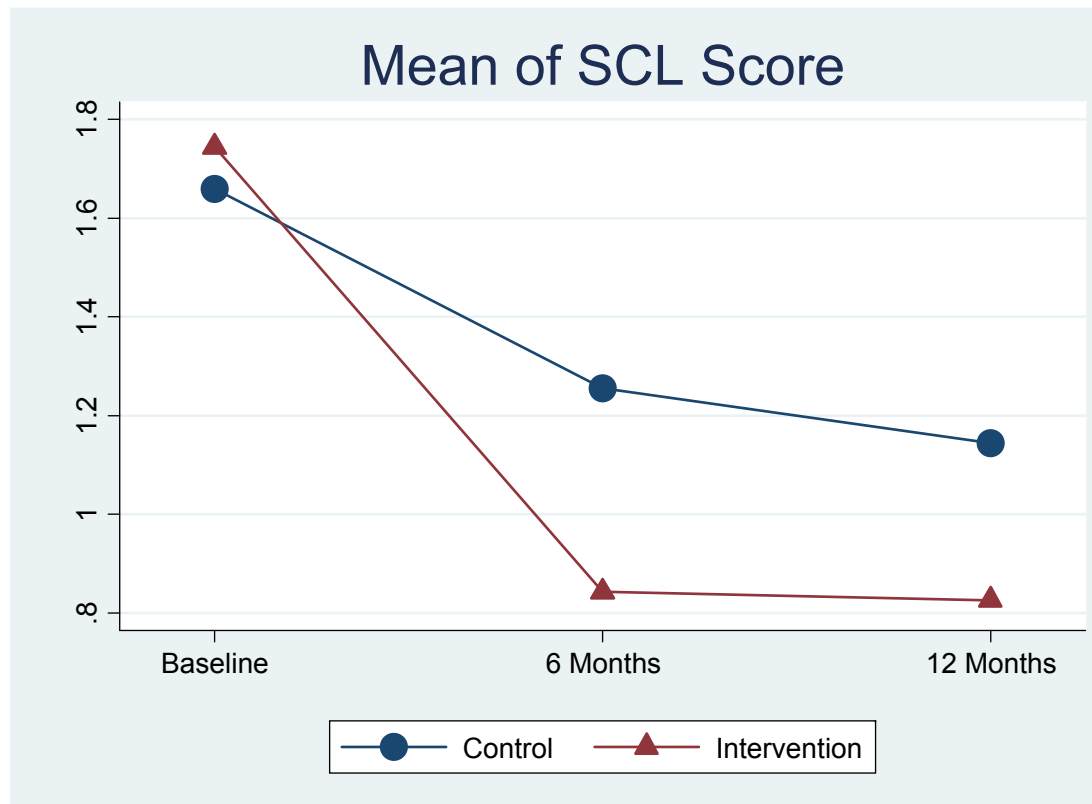
Behavioral activation/exercise

Dietary changes

Checking blood glucose/altering insulin

Cessation of smoking

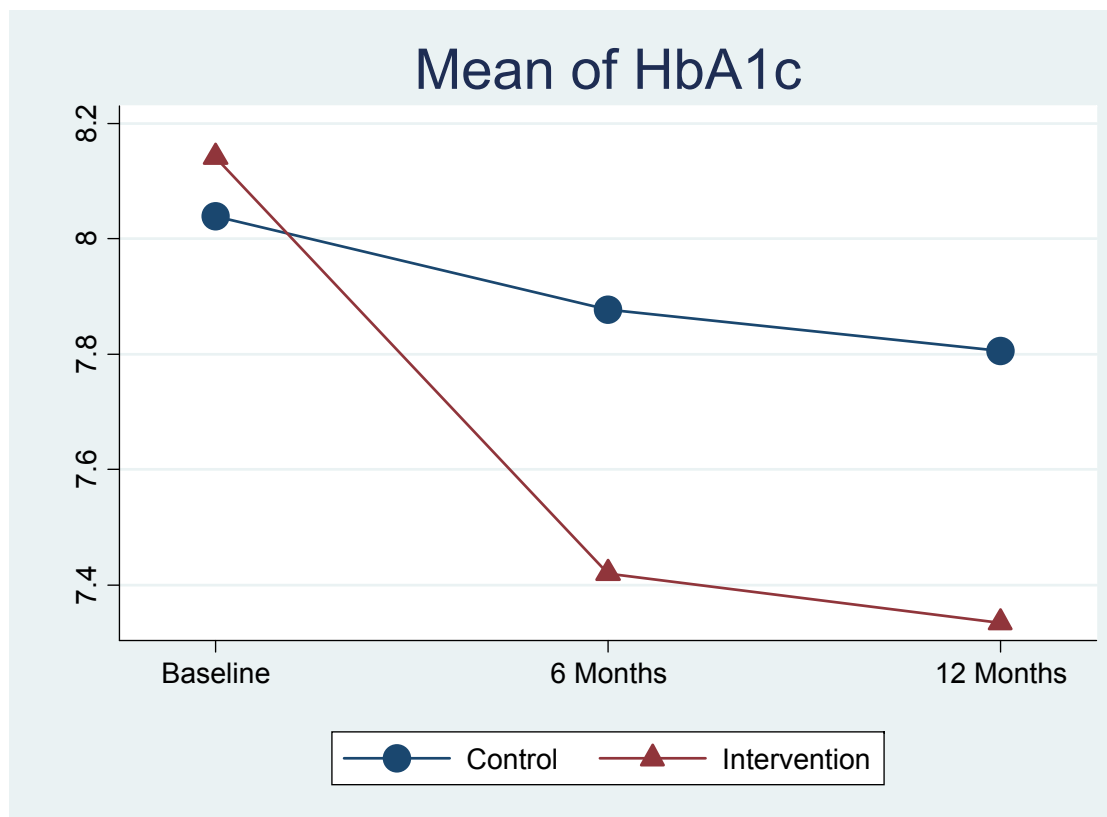
Depression Scores



	Baseline	6 months	12 months
Intervention mean (N)	1.7 (105)	0.8 (97)	0.8 (94)
Control mean (N)	1.7 (106)	1.3 (96)	1.1 (92)

Katon WJ et al. N Engl J Med. (2010) 363(27):2611-20.

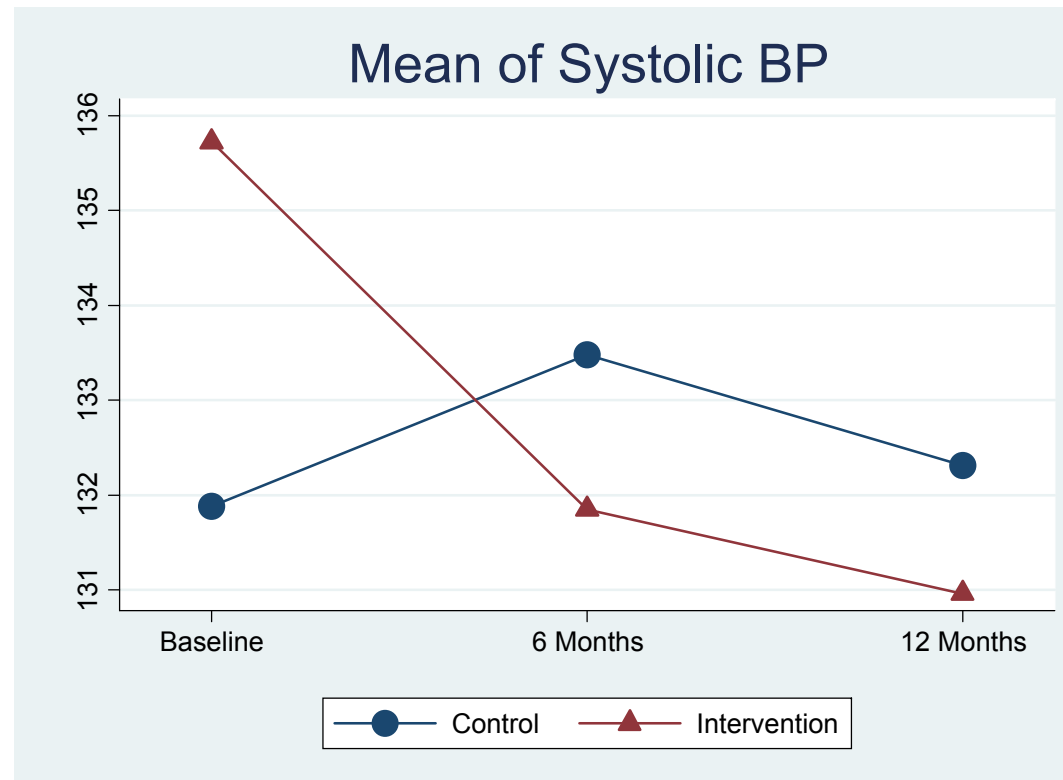
HbA1c



	Baseline	6 months	12 months
Intervention mean (N)	8.1 (105)	7.4 (99)	7.3 (101)
Control mean (N)	8.0 (105)	7.9 (95)	7.8 (97)

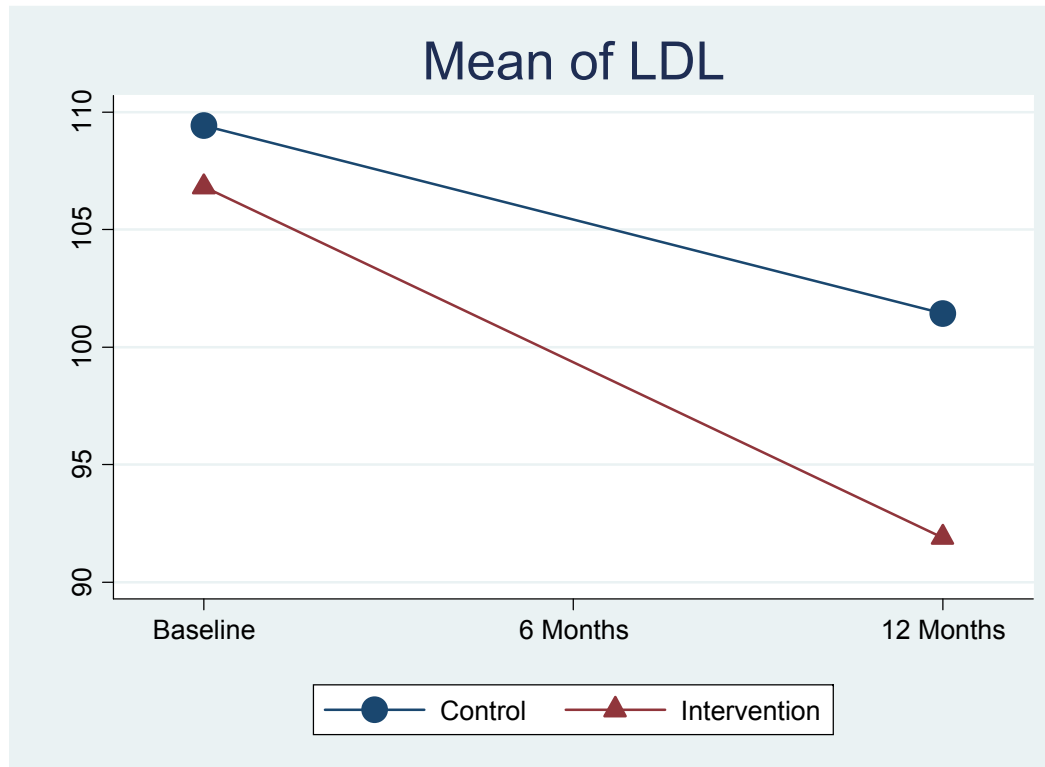
Katon WJ et al. N Engl J Med. (2010) 363(27):2611-20.

Systolic BP



	Baseline	6 months	12 months
Intervention mean (N)	135.7 (105)	131.9 (102)	131.0 (101)
Control mean (N)	131.9 (106)	133.5 (101)	132.3 (101)

Mean LDL



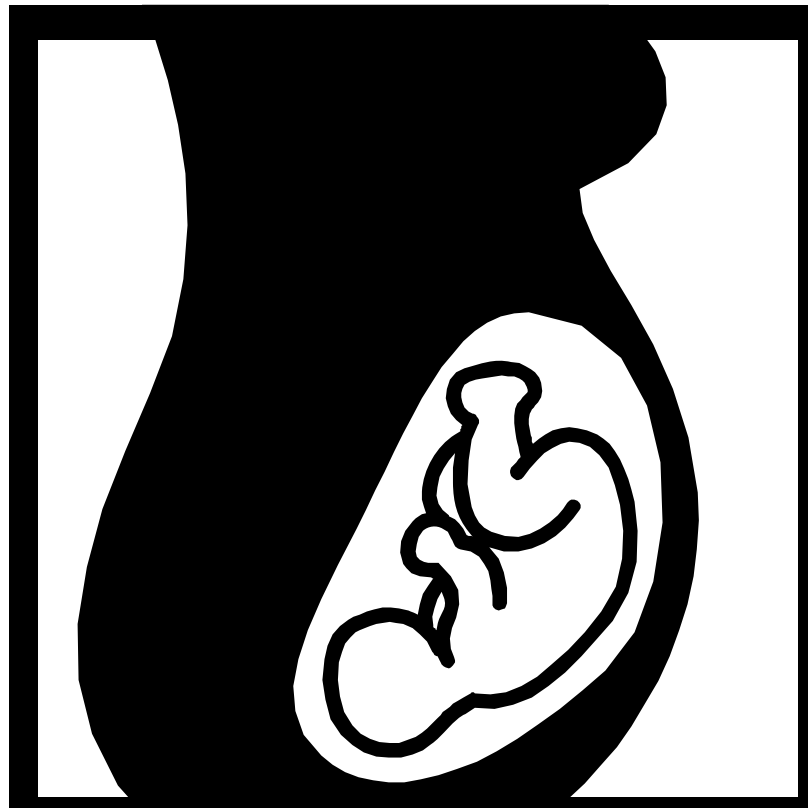
	Baseline	6 months	12 months
Intervention mean (N)	106.8 (105)	N/A	91.9 (98)
Control mean (N)	109.4 (103)	N/A	101.4 (90)

Katon WJ et al. N Engl J Med. (2010) 363(27):2611-20.

TEAMcare

<http://www.teamcarehealth.org>

Pregnant Women



Pregnancy and the Post-Partum Period

- **Adjustment disorders**
- **Depression**
- **Anxiety**
- **More serious psychiatric disorders**
 - **Mania**
 - **Psychosis**
 - **OCD**

Risks of Depression in Pregnancy

- **Preterm birth (PTB)¹**
- **Low birth weight (LBW)¹**
- **Postpartum depression**

¹ Grote NK, Bridge JA, Gavin AR, Melville JL, Iyengar S, Katon WJ. (2010) Arch Gen Psychiatry 67(10):1012-24.

Screening

- **Consider PHQ-9 or Edinburgh Postnatal Depression Scale as part of obstetric care:**
 - **At initial assessment**
 - **At post partum appointment**
- **Referrals from OB care providers**

Treatment in Primary Care?

Assess severity of impairment

For mild to moderate symptoms

Evidence-based psychotherapy

Care manager support

For more severe symptoms

Consider medications

Stepped care for more severe symptoms

Protocols for hospitalization as needed

PCP Information: Medications -General Principles

Treatment involves weighing the risks of the illness vs. the risk of medication

There are no perfectly “safe” medications – all involve some degree of risk

Typically we have a higher threshold for using medications during pregnancy

Informed consent is key and if possible should involve the partner

Abrupt discontinuation may lead to earlier relapse or withdrawal symptoms

PCP Information:

Balancing Antidepressant Risks and Benefits

Risks of not taking medication

- Relapse risk
- Poor prenatal care
- Decreased maternal weight gain
- Preterm labor
- Low birth weight
- Prematurity
- Increased post-partum depression
- Poor bonding / attachment
- Greater risk of depression in children

Risks of taking medication:

Clear evidence:

- Increased rate of miscarriage
- Preterm delivery (by approx 1 week)
- Neonatal toxicity / withdrawal
- Passage into breast milk to some degree (sertraline the least)

Modest evidence:

- Heart defects (paroxetine)

Mixed evidence:

- Primary Pulmonary Hypertension of the Newborn (PPHN)
- Lower Bayley psychomotor developmental indexes and motor quality in f/u 6-40 months

Emerging evidence:

- Increased risk of HTN (~2X) and preeclampsia in women taking SSRIs (~5X) during pregnancy
- SSRIs associated with increased incidence of autism (1 study)

PCP Information: Medications - General Principles

Most of the toxicity to the fetus occurs during the first trimester but craniofacial anomalies and neurobehavioral effects can occur later in pregnancy

Toxicities to the fetus include:

- (1) Major malformations (base rate is 3%)**
- (2) Minor malformations**
- (3) Adverse pregnancy outcomes (e.g., miscarriage)**
- (4) Neonatal toxicity (e.g., withdrawal)**
- (5) Neurobehavioral effects**

Good reference:

Micromedex REPROTOX®, MGH Center for Women's Health: <http://www.womensmentalhealth.org>

PCP Information: Antidepressants

- **SSRIs, SNRIs, Remeron, TCAs, & Wellbutrin are overall considered reasonably safe during pregnancy**
 - **Exceptions include paroxetine, imipramine, and nortriptyline**
- **Risks vs. Benefits**

PCP Information: Other Psychotropic Medications

Antianxiety and sleep (hypnotic) medications:

- **Benzodiazepines (e.g., lorazepam):** Concerns about withdrawal after birth and long-term neurobehavioral problems
- **Hydroxyzine:** relatively safe; helpful for sleep
- **Zolpidem (Ambien):** used a great deal but long term toxicities unknown

Mood Stabilizers:

- **Lithium:** Increased risk of cardiac malformation during 1st trimester; considered fairly safe after 1st trimester; not safe for breastfeeding
- **Divalproex:** Considered unsafe during pregnancy due to major and minor malformations; passes into breast milk
- **Lamotrigine:** Increased risk of cleft lip; safer than Depakote

Antipsychotics / Mood Stabilizers:

- **Haloperidol:** 1st choice during pregnancy & breast feeding
- **Atypical antipsychotics:** Not a lot known about long-term safety; 2nd choice; avoid in breastfeeding

Older Adults



Primary Care Geriatric Behavioral Health

- **The '3 Ds'**
 - **Depression**
 - **Dementia**
 - **Delirium**
- **Stressors**
 - **Losses**
 - Loss of loved ones
 - Loss of functioning independence

Depressive Syndromes

Other depressive syndromes

- Minor / subthreshold depression
- Depression due to medical illness / medication
- Adjustment disorder with depressed mood
- Grief & bereavement

Major depression

- 5/9 symptoms
for ≥ 2 weeks

Dysthymic disorder

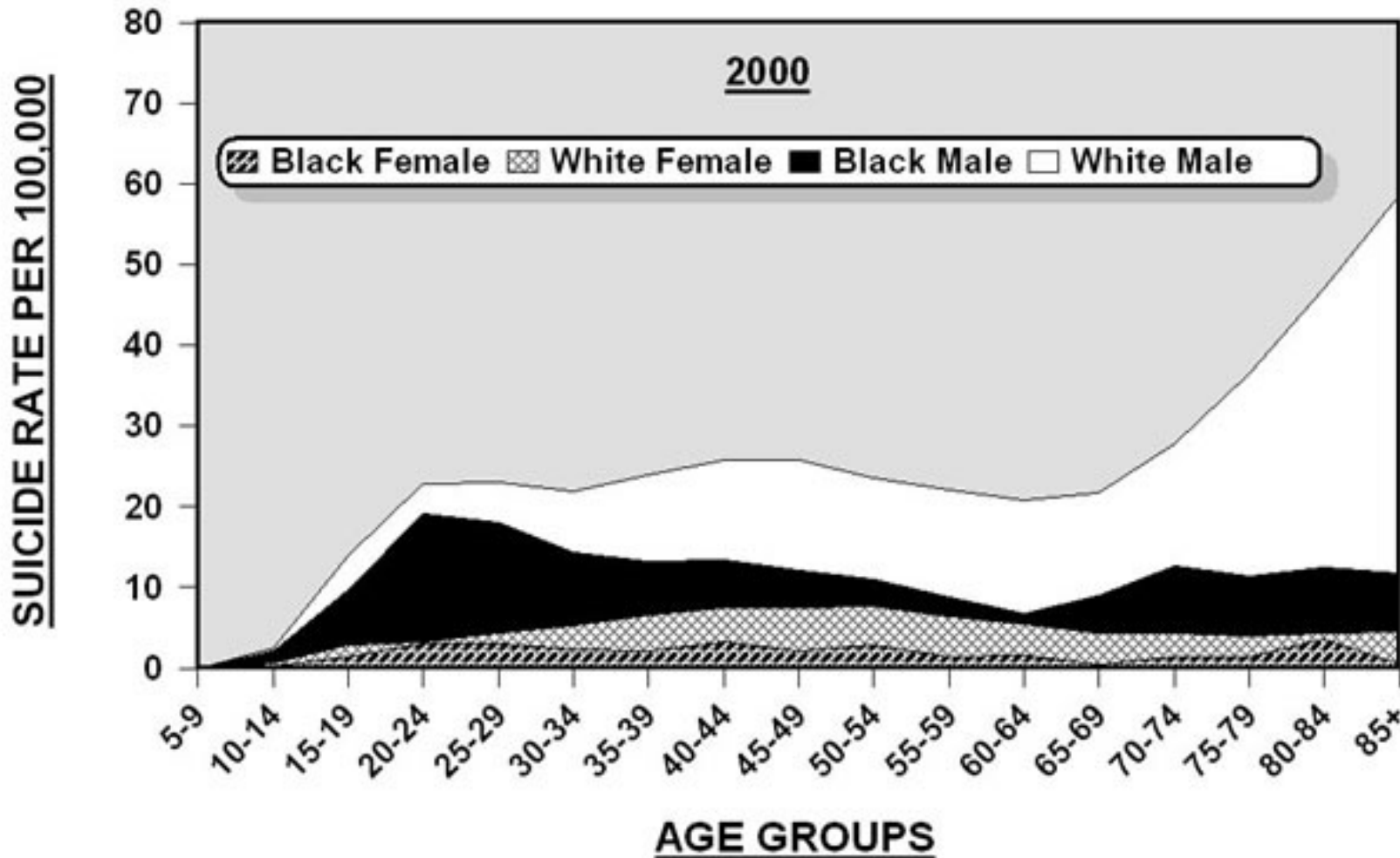
- Chronic (≥ 2 years)

Bipolar Depression

- History of mania or hypomania

Depression is deadly

Older men have the highest rate of suicide.



Source: National Institute of Mental Health
Data: Centers for Disease Control And Prevention, National Center For Health Statistics



IMPACT Summary

Photo credit: J. Lott, Seattle Times

Less depression

→ IMPACT doubles effectiveness of usual care

Less physical pain

Better physical functioning

Higher quality of life

Greater patient & provider satisfaction

Lower health care costs

Over 40 peer-reviewed publications

<http://impact-uw.org>



“I got my life back”

Depression – ‘Medical’ Contributors

Common medical causes of depressed mood or clinical depression

Neurological Disorders

- CVA
- Parkinson’s disease
- Huntington’s disease
- Multiple sclerosis

Cardiovascular disease

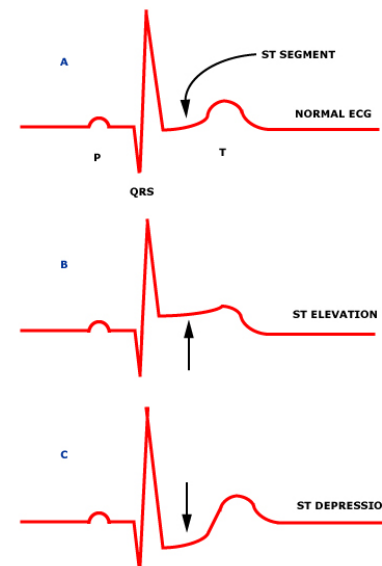
- Vascular depression

Obstructive sleep apnea

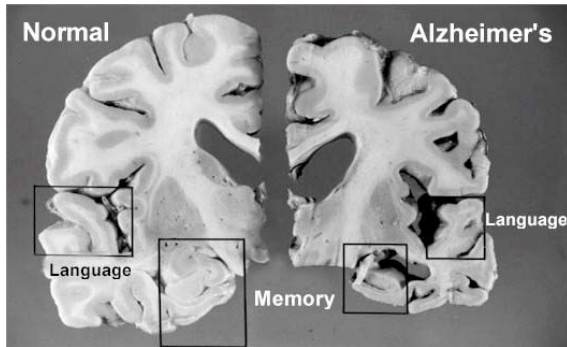
Cancers

- Pancreatic cancer

HIV



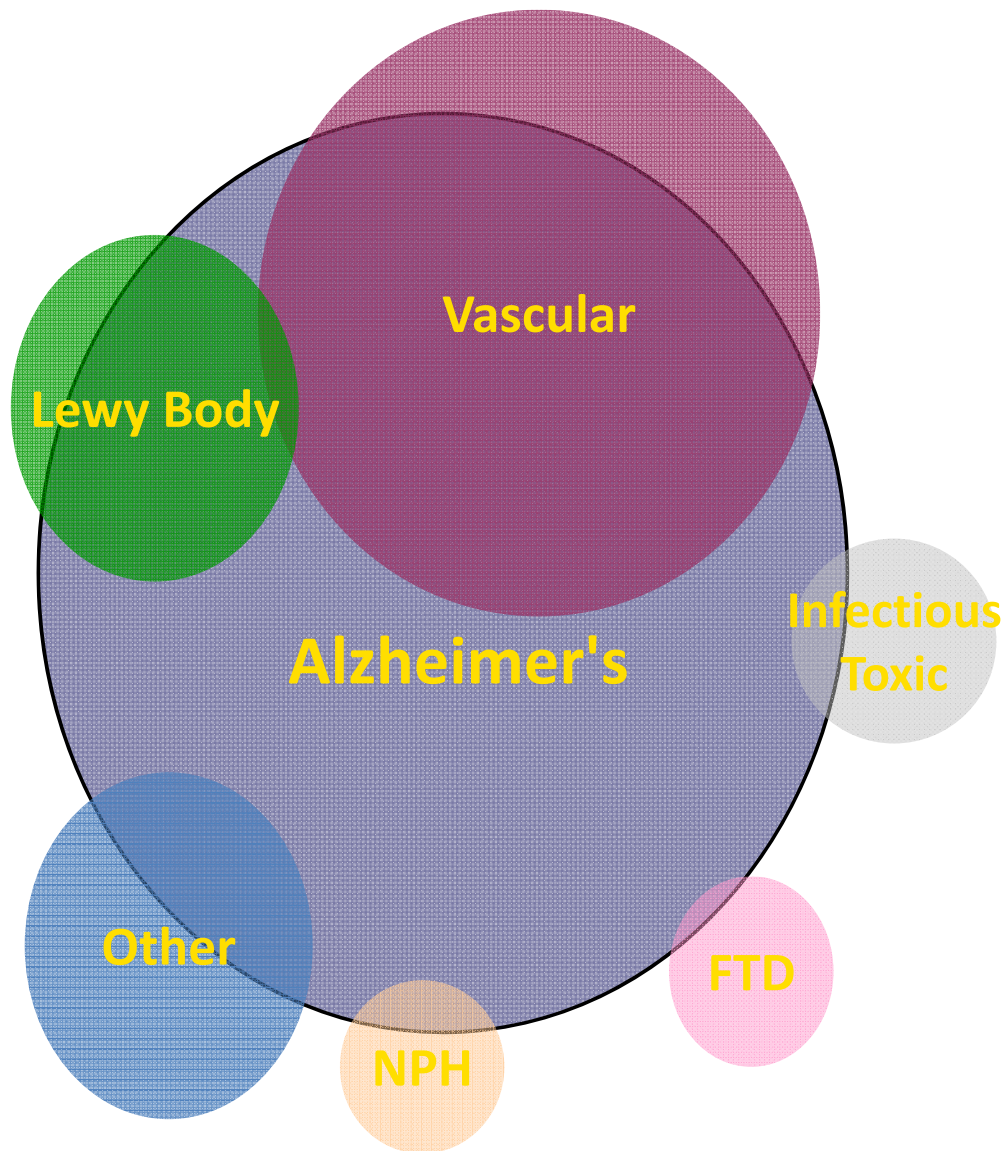
Cognitive Impairment



‘Brain Failure’

Acute = Delirium
Chronic = Dementia

Support PCPs Assessment of Cognitive Impairment



- History:
 - Dementia has gradually onset
- Abrupt cognitive change:
 - Stroke
 - Intoxication effect (meds, substances)
 - Delirium
- Assess cognition with screener (Mini-Cog)

Primary Care Cognitive Workup

- Focused history, mental status exam, and physical exam.
- Functional assessment
- Rule out delirium and depression
- Basic tests: CBC, Chem-7, VDRL, B12, folate, thyroid, calcium
- Brain imaging (CT, MRI, ? PET /SPECT)

Mini-Cog: Delayed recall +Clock drawing

- “Remember these 3 words:
apple, table, penny”

- Repeat until can repeat all
three words

- “Draw a clock face”

- “Put on the numbers”

- “Put on hands to make
the time be ELEVEN-
TEN”

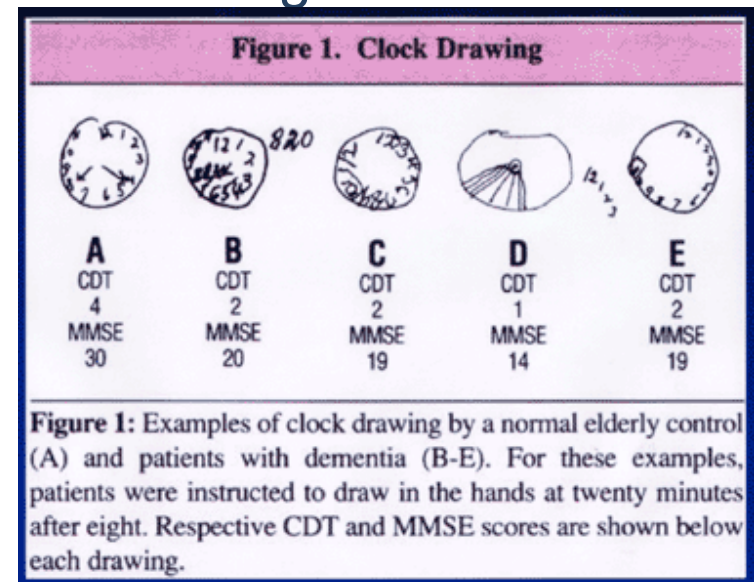
- “What were the 3 items?”

Scoring:

- Clock drawing: 2pts if no errors
(*NO PARTIAL CREDIT!!*)
- Each delayed recall item: 1pt

Interpretation:

- 0-2: Positive screen
- 3-5: Negative screen



Primary Care Treatment for Dementia

Rule out and treat a medical cause or superimposed delirium

Environmental, behavioral, and other nonpharmacologic therapies

Treat unrecognized moderate to severe depression with SSRIs

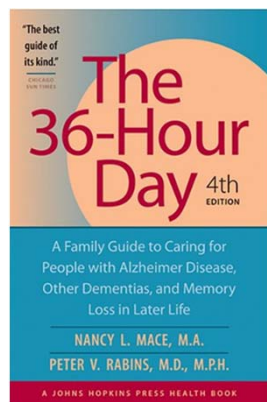
Support care giver

Antipsychotic agents have limited efficacy and are associated with increased mortality in patients with dementia.

PCP Information: Dementia Treatment

Care of the Caregiver

- Listen
- Screen family members and caregivers for depression
- Focus on quality of life for whole family unit
- Recommend the Alzheimer's Association, County Senior Services, private social workers



Cognitive Enhancers

- Donepezil
 - Start 5mg QDay, Max 10mg QDay
- Rivastigmine
 - Start 1.5mg BID, Max 6mg BID
- Galantamine
 - Start 4mg BID, Max 12mg BID
- Memantine
 - Start 5mg QDay, Max 10mg BID

PCP Information: Antipsychotic risks

- Increase risk for sudden death
 - Both conventional and atypical antipsychotics
 - Risk increased with higher medication dose.
 - The rate of sudden death with antipsychotics (1.8 per 1,000 person years)
- Weight gain, diabetes and other metabolic abnormalities
 - Especially olanzapine and quetiapine
 - Baseline assessment of weight, blood pressure, fasting plasma glucose, and fasting lipid profile, and reassessment after 12 weeks
- Tardive dyskinesia
- Extrapyramidal symptoms
- Akathisia
- Neuroleptic malignant syndrome

PCP Information: Antipsychotic risks

- ALL antipsychotic medications have been shown to be associated with an increased risk of mortality when used to treat elderly patients
 - FDA issued a public health advisory in 2008 highlighting these findings and emphasizing that antipsychotics are not approved for the treatment of dementia-related psychosis.
- Evidence regarding stroke risk associated with atypical antipsychotic drugs is conflicting.
 - A large cohort study of adults aged ≥ 65 years found a similar risk of ischemic stroke among users of atypical versus typical antipsychotics.
 - A study of the time concurrence of antipsychotic use and stroke in patients who both used antipsychotics and had a stroke found the risk of stroke was greater during the time period an antipsychotic was used, was greater for atypical than typical antipsychotics, and was greatest for patients with dementia.

Practical antipsychotic prescribing

- In dementia, reserve antipsychotics for cases with highest potential benefit ONLY
 - Physically aggressive behavior
- Use lowest effective dose (starting – max dose)
 - Olanzapine 2.5-10mg
 - Quetiapine 25-150mg
 - Risperidone 0.5-1mg
 - Aripiprazole 1-5mg
 - Ziprasidone 20-80mg (with food)
- Mortality risk should be discussed with patients, families, and other caregivers if antipsychotics are prescribed.

Role of Primary Care Psychiatrist

Role of Primary Care Psychiatrist

- Help team assess 'medical causes and contributions'
 - Medical illnesses
 - Medications
- Help adapt behavioral interventions to patients' medical conditions
 - Medical illnesses
 - Special populations (e.g., pregnancy, older adults)



Consult on Patients that Don't Improve!

- Is the diagnosis correct?
- Is the patient adhering to treatment & is the dose enough?
- Are there other medical / psychological / social problems / life stressors?

Medical Patients with Psychiatric Illness: Key Strategies

- **Communication**
 - Identify team members: Do you need additional expertise?
 - Team meetings?
- **Education**
 - Clear, protocol driven medication recommendations
 - Other specific interventions
- **Stepped support for difficult patients**
 - Need for additional resources?
 - More in person assessment?

Reflection Questions

Reflective Thinking

- What role do I see for myself in addressing medical co-morbidity in my consultations?
- How comfortable am I in addressing chronic pain as part of my practice?
- Do I have enough experience to provide consultation to the special populations in my practice?

Adapt to Practice (including team building)

- Name the ways in which your current practice is proactive in the identification and treatment of medical co-morbidity
- Name the ways in which your current practice is proactive in the identification and treatment of chronic pain
- Identify the special populations you serve and adaptations of your practice needed to meet special needs

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