Primary Care Consultation Psychiatry

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Providing information, experts, and resources dedicated to behavioral health and primary care integration

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Building on 25 years of Research and Practice in Integrated Mental Health Care
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
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

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 $\Leftrightarrow$ 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)

- Baseline
- 3 months
- 6 months
- 12 months

Lin et al., *JAMA*, 2003
But: Pain Impedes Improvements in Depression

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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)
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)

## Depression Increases Odds of Complications and Mortality

<table>
<thead>
<tr>
<th>Major Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Microvascular Complications</td>
</tr>
<tr>
<td>1.33 (1.08, 1.65)</td>
</tr>
<tr>
<td>Macrovascular Complications</td>
</tr>
<tr>
<td>1.38 (1.08, 1.78)</td>
</tr>
<tr>
<td>Mortality (All cause)</td>
</tr>
<tr>
<td>1.53 (1.19, 196)</td>
</tr>
<tr>
<td>Foot Ulcers</td>
</tr>
<tr>
<td>1.99 (1.22, 3.24)</td>
</tr>
<tr>
<td>Dementia</td>
</tr>
<tr>
<td>2.69 (1.77, 4.07)</td>
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</tbody>
</table>

Depression and Heart Disease/Diabetes: Adverse Bidirectional Interaction

Major Depression
- Smoking
- Sedentary lifestyle
- Obesity
- Lack of adherence to medical regimens
- Psychophysiological
- Insulin sensitivity
- Autonomic NS
- Inflammatory markers

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

Katon et al., *Biol Psychiatry*, 2003
Depression, Diabetes, and Heart Disease

Pathways and Teamcare Studies
Wayne Katon, MD\textsuperscript{1} & Colleagues\textsuperscript{2}

\textsuperscript{1} University of Washington School of Medicine
\textsuperscript{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
- $\text{PHQ-9} > 10$
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

#### Mean of SCL Score

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>6 months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
<td>1.7 (105)</td>
<td>0.8 (97)</td>
<td>0.8 (94)</td>
</tr>
<tr>
<td><strong>Control</strong></td>
<td>1.7 (106)</td>
<td>1.3 (96)</td>
<td>1.1 (92)</td>
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</table>

## HbA1c

### Mean of HbA1c

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>6 months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
<td>8.1 (105)</td>
<td>7.4 (99)</td>
<td>7.3 (101)</td>
</tr>
<tr>
<td><strong>Control</strong></td>
<td>8.0 (105)</td>
<td>7.9 (95)</td>
<td>7.8 (97)</td>
</tr>
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</table>

Systolic BP

Mean of Systolic BP

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>6 months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention mean (N)</td>
<td>135.7 (105)</td>
<td>131.9 (102)</td>
<td>131.0 (101)</td>
</tr>
<tr>
<td>Control mean (N)</td>
<td>131.9 (106)</td>
<td>133.5 (101)</td>
<td>132.3 (101)</td>
</tr>
</tbody>
</table>

Mean LDL


<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>6 months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention mean (N)</td>
<td>106.8 (105)</td>
<td>N/A</td>
<td>91.9 (98)</td>
</tr>
<tr>
<td>Control mean (N)</td>
<td>109.4 (103)</td>
<td>N/A</td>
<td>101.4 (90)</td>
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</table>
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)
- Low birth weight (LBW)
- Postpartum depression

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
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.
IMPACT Summary

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

“I got my life back”

Over 40 peer-reviewed publications
http://impact-uw.org
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

Figure 1. Clock Drawing

- A: CDT 4 MMSE 30
- B: CDT 2 MMSE 20
- C: CDT 2 MMSE 19
- D: CDT 1 MMSE 14
- E: CDT 2 MMSE 19

Figure 1: Examples of clock drawing by a normal elderly control (A) and patients with dementia (B-E). For these examples, patients were instructed to draw in the hands at twenty minutes after eight. Respective CDT and MMSE scores are shown below each drawing.
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.
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
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

- 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
Chronic Pain:

Medical Co-morbidity:
References

Pregnancy and Lactation:


• MGH Center for Women’s Mental Health http://www.womensmentalhealth.org/

Older Adults:
