Managing Behavioral Health Services in a Primary Care Setting

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Conflicts of Interests

Nothing to disclose

Behavioral Health in Primary Care

- Depression and Anxiety
- Psychotic disorders
- Substance use
- Neurocognitive disorders
- ADHD
- Sleep disorders
- Eating disorders
- Trauma/ stress-related disorders
- Personality disorders
- Suicide/ risk assessment

Behavioral Health in Primary Care

- Up to 75% of primary care visits include mental or behavioral health components.
- "Behavioral Health Crisis": the number of people with mental health conditions and substance use disorders is rising, yet many people cannot easily access the treatment they need.
- Primary care teams must address many common mental health disorders, such as depression, anxiety and substance abuse.
- Behavioral factors related to *chronic disease management*: substance use, tobacco use, and the impact of stress, diet, and exercise on health. Treatment non-adherence.

Behavioral Health in Primary Care

- Barriers to Care
  - Provider shortages
  - Gaps in insurance coverage, high out-of-pocket costs
  - Stigma, shame
  - Failure to recognize illness and/or the usefulness of treatment
  - Illness itself may be deterrent (apathy, anergia)

- Challenges in the Primary Care Setting
  - Limited time
  - Limited resources
  - Often difficult-to-manage patients

Behavioral Health in Primary Care: "Integrated Practice"

- Behavioral health consultant (BHC) — a psychologist, licensed clinical social worker, or other behavioral health professional — as a member of the health care team
- Common elements exist across models, including:
  - Team-based care
  - Universal screening for common behavioral and physical health disorders
  - Shared information systems, such as electronic health records, to improve coordination across providers while maintaining patient privacy
  - Measurement of patient outcomes
  - Engagement with social and community behavioral health services

Behavioral Health in Primary Care: “Integrated Practice”

- AMA and other leading medical associations have established the **Behavioral Health Integration (BHI) Collaborative**, a group dedicated to catalyzing effective and sustainable integration of behavioral and mental health care into physician practices.
- Behavioral health integration practice guides focus on four key areas of effective integrated care:
  - Practice workflow design (e.g. staffing, protocols for crisis, technology, billing & coding)
  - Pharmacological treatment (including psychopharm “How-to guide”, screening/assessment tools)
  - Substance use disorder screening and treatment
  - Suicide prevention

Depression: Assessment

- Feelings of sadness, tearfulness
- Diminished interest or pleasure
- Low energy, fatigue
- Insomnia or hypersomnia
- Change in appetite, weight loss
- Psychomotor agitation or retardation
- Feelings of worthlessness or guilt
- Poor concentration
- Thoughts of death or suicide

- Headache, pain, other physical symptoms
- Anxiety, nervousness
- Irritability, anger

- ? Psychotic features
- R/o Bipolar
- Suicide/ safety assessment

Depression: Assessment

- **Medical conditions** associated with increased risk for depression include: chronic pain, diabetes, cancer, HIV, Parkinson's disease, cardiovascular and cerebrovascular disease, and multiple sclerosis
- Also conditions that may cause fatigue or other symptoms: CFS, ‘Long Covid’, sleep apnea
- Medications that might cause fatigue or other symptoms

- Special populations:
  - Pregnant and postpartum women
  - Geriatric and cognitively impaired patients

Screening tools

- Patient Health Questionnaire

  PHQ-2 and PHQ-9
- Beck Depression Inventory (BDI)
- Geriatric Depression Scale (GDS)
- Zung Self-Rating Depression Scale

Appendix A – Patient Health Questionnaire (PHQ-9)

PATIENT HEALTH QUESTIONNAIRE-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING

0 + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Depression: Treatment

Antidepressants: how to choose the right drug?

- Side effect profile
- Prior response, family hx
- Convenience, access, cost

Other somatic treatments: ECT, TMS

Psychotherapies: individual and group

Activity, exercise, diet, sunlight

Medications Used to Treat Depression

First Line Medications:

– Selective Serotonin Reuptate Inhibitors (SSRI)

Alternative Medications:

- Serotonin/Norepinephrine Reuptake Inhibitors (SNRI)
- Bupropion
- Mirtazepine
- Tricyclic Antidepressants (TCA)
- Trazodone

Receptor – Based Side Effects

5-HT effects: GI effects, sexual side effects, “serotonin syndrome”

Anticholinergic effects

- Central: confusion, agitation, hallucinations
- Peripheral: dry mouth, constipation, urinary retention, blurry vision

α - adrenergic blockade: Orthostatic hypotension → falls

Dopamine blockade: extrapyramidal symptoms (EPS) (including parkinsonism)

General CNS side effects: sedation, somnolence, confusion, worsening depression

General cardiovascular effects: QTc prolongation

Selective Serotonin Reuptake Inhibitor (SSRI)

<u>Traditional SSRIs</u>

- Citalopram (Celexa®)
- Fluoxetine (Prozac®)
- Paroxetine (Paxil®)
- Escitalopram (Escitalopram®)
- Sertraline (Zoloft®)
- Fluvoxamine (Luvox®)

<u>Newer SSRIs</u>

- Vilazodone (Viibryd®)
  - SSRI + 5-HT_{1A} partial agonist
- Vortioxetine (Triltellix®) ***no generic***
  - SSRI + 5-HT_{1A} agonist + 5-HT_{3} antagonist

Serotonin/ Norepinephrine Reuptake Inhibitor (SNRI)

Traditional SNRIs

- Duloxetine (Cymbalta®)
- Venlafaxine HCI (Effexor®)
- Desvenlafaxine succinate (Pristiq®)

Newer SNRI Formulations

- Levomilnacipran (Fetzima®) ***no generic***
- Duloxetine sprinkles (Drizalma®) ***no generic***
- Venlafaxine besylate 112.5mg ER

Tricyclic Antidepressants

Affected Receptors: 5-HT, NE, H_1, ACh, α-1

Side effects: Sedation, anticholinergic, weight gain, GI Upset, sexual dysfunction

Tertiary Amines: More side effects

- Imipramine (Tofranil®)
- Amitriptyline (Elavil®)
- Clomipramine (Anafranil®)
- Doxepin (Silenor®)

Secondary Amines: Fewer side effects

- Nortriptyline (Pamelor®)
- Desipramine (Norpramin®)
- Amoxepine (Asendin®)

Other Medications

Bupropion: DA and NE reuptake inhibitor

- No sexual dysfunction
- Lowers the seizure threshold

Mirtazepine: antagonist of H_1, 5-HT_2, and 5-HT_3

- Less sexual dysfunction but **significantly** more weight gain
- Sedative properties can be beneficial for insomnia

Trazodone: 5-HT reuptake inhibitor as well as H_1 antagonist

- H_1 antagonistic effects occur at lower doses
- 5-HT effects occur at higher doses

A COMPARISON OF DEPRESSION MEDICATIONS

Class	Medication	Anti-colinergic	Sleepy	Insomnia/ Aggitation	Orthostatic Hypotension	QT	GI	Weight Gain	Sexual	Approx. cost per month	Comments
SSRI	*Citalopram/ Escitalopram (Celexa/Lexapro)*	0	0	1+	1+	1+	1+	1+	3+	$4 $20	Escitalopram (Lexapro) is the S isomer of citalopram. Citalopram is cheaper.
SSRI	*Fluoxetine (Prozac)*	0	0	2+	1+	1+	1+	1+	3+	$4	Has the longest halflife. Therefore, caution with using in elderly
SSRI	*Paroxetine (Paxil)*	1+	1+	1+	2+	1+	1+	2+	4+	$4	Shortest halflife. **Pregnancy class D**
SSRI	*Sertraline (Zoloft)*	0	0	2+	1+	1+	2+	1+	3+	$10	Has many other indications besides depression such as panic disorder
DOPAMINE NOREPINEPHRINE REUPTAKE INHIBITOR	*Bupropion (Wellbutrin)*	0	0	2+	0	1+	1+	0	0	$30	Frequently used as adjunct to SSRIs for depression. Also used for tobacco cessation. Can decrease seizure threshold
SNRI	*Venlafaxine ER (Effexor XR)*	0	0	2+	0	1+	2+	0	3+	$19	May increase blood pressure
SEROTONIN MODULATOR	*Trazodone*	0	4+	0	1+ or 3+	1+ or 2+	1+ or 3+	1+ or 2+	1+	$4	Often used off-label for treating insomnia. Doses for treating insomnia are much lower.
NORADRENERGIC AND SPECIFIC SEROTONERGIC ANTIDEPRESSANT	*Mirtazapine (Remeron)*	1+	4+	0	0	1+	0	4+	1+	$15	May be reasonable to start on undernurished patients
TCA	*Amitriptyline (Elavil)*	4+	4+	0	3+	3+	1+	4+	3+	$4	Lethal in overdose. Also used for treating migraines and chronic pain.

Adapted from UpToDate

Onset of Action vs. Therapeutic Trial

Onset of action: 2 – 4 weeks

- Some impact on symptoms and psych evaluations such as PHQ-9 and GAD-7
- What to do next?
  - Continue to follow up with patient every 2 – 4 weeks
  - If patient is tolerating the medication, the dose can be increased

Therapeutic Trial: 8 – 12 weeks on the maximum tolerated dose

- Maximum impact on symptoms and psych evaluations
- What to do next: Switch to a different agent or add a med to augment therapy

Depression treatment: Next steps

Has patient reached **remission**?

If not improving on initial treatment…

- Evaluate dose, duration; adherence to treatment
- Reconsider treatment modality
- Reconsider diagnosis
- Reconsider impact of comorbidities
- Consider other strategies

Depression treatment: Next steps

If not improving on initial treatment…

- More time, dose adjustment?
- Change med (different class)

Augmentation/combinations:

- Add atypical antipsychotic
- Add tricyclic to SSRI
- Add bupropion or mirtazapine to SSRI
- Add lithium
- Add buspirone
- Add stimulant - e.g. methylphenidate (Ritalin)

Depression treatment: Next steps

- ECT (electroconvulsive therapy) especially for…
  - Severe or psychotic depression
  - Not eating
  - Catatonic
  - Suicide risk

- TMS, ketamine

- Partial hospital program; inpatient treatment

Anxiety

- As a component of depression, or a separate condition
- Generalized anxiety disorder, panic disorder, OCD
- Co-morbidity: mood disorders, substance use, ADHD, trauma-related disorders
- Assessment: DSM5; GAD-7

- Therapy: cognitive behavioral therapy (CBT)
- Mindfulness, stress reduction strategies
- Exercise

- Medication treatment: “antidepressants”, benzodiazepines, buspirone

Medications to Treat Anxiety

Maintenance Medications: 2 – 4 week onset

Goal: Minimize frequency of anxiety symptoms

- First line medications:
  - SSRIs
  - SNRIs
- Alternative medications:
  - Buspirone
  - TCAs

Acute Medications: Immediate onset

Goal: Relieve acute anxiety symptoms

- Benzodiazepines

Buspirone (Buspar®)

Mechanism of action: Affinity for 5-HT and DA

Dose frequency: BID – TID

Onset: 2 – 4 weeks

Adverse effects: Nausea, GI upset, dizziness, insomnia

Benzodiazepines

Place in therapy: To control acute anxiety until stablized on chronic therapy

Benzodiazepine	Onset of Action	Peak Onset (hrs)	Half-life parent (hrs)	Half-life metabolite (hrs)
Long Acting				
Diazepam (Valium®)	Rapid (po, IV)	1(po)	20-50	3-100
Intermediate Acting				
Alprazolam (Xanax®)	Int.	0.7-1.6	6-20	-
Clonazepam (Rivotril®)	Int.	1-4	18-39	-
Lorazepam (Ativan®)	Int. (po), Rapid (sl, IV)	1-1.5 (po)	10-20	-
Temazepam (Restoril®)	Slow	0.75-1.5	10-20	-
Short Acting				
Triazolam (Halcion®)	Int.	0.75-2	1.6-5.5	-

Questions?