Primary Care: Referring to Psychiatry

Carol Capitano, PhD, APRN-BC
Assistant Professor, Clinical Educator
University of New Mexico College of Nursing
University of New Mexico Psychiatric Center
Objectives

1. Identify 3 symptoms that require referral to psychiatry.
2. List 3 barriers that prevent referrals.
4. List 5 resources for psychiatric referrals in New Mexico.
NEW MEXICO STATISTICS
Psychiatric Prescribers

- Psychiatrists
  - 289
  - 21% (69) - child and adolescent specialty

- Psychiatric Advanced Practice Nurses
  - 114 (NP/CNS)

- Prescribing psychologists
  - 25

- Eight New Mexican counties lack access to prescribers who specialize in behavioral health (Catron, De Baca, Guadalupe, Harding, Hidalgo, Mora, Sierra and Union)
REFERRALS
Types of Referrals

- Evaluation & referral
- Evaluation, initial treatment, referral back to PCP
- Consultation & evaluation with recommendations
- Consultation & evaluation with supervision by practitioner
- Consultation without face-to-face evaluation:
  - Clinic treatment team
  - School intervention team

American Academy of Child Adolescent Psychiatry, 2015
Lipsitt, 2013
Knowing When to Refer

- Suicidal Ideations
- Psychotic symptoms
- Diagnostic questions
- Developmental issues
  - Child/Adolescent
- Management review
- Psychopharmacology assessment/review

- Substance abuse
- Signs of dementia
- Sleep disorders
- Abnormal bereavement
- Refractory depression
- Bipolar Affective Disorder

Lipsitt, 2013
Referral Examples

- Treatment Resistant Depression
  - Failed trials and psychotherapy

- Psychosis
  - Loss of contact with reality, delusions or hallucinations

- Bipolar Affective Disorder
  - Major depression with periods of mania

- Comorbidity with other psychiatric illnesses
  - Depression + alcoholism
  - Depression + anxiety

Liebowitz, 2005
Adolescent Referrals

- Emotional or behavioral problems
  - Danger to self or others
  - Primary caretaker has serious impairment or substance abuse issues
- Significant change in behavior with no obvious precipitant
- Behavioral issues that interfere with chronic medical treatment
- No improvement in behaviors with 6-8 weeks of treatment
- History of abuse, neglect, removal from home
- Complex diagnostic issues
- Treated with more than 2 psychotropic medications w/o improvement

American Academy of Child and Adolescent Psychiatry, 2015
Barriers to Referrals

- Stigma
  - Work
  - Social
- Fear of losing PCP as a provider
- Insufficient number of psychiatric providers or mental health centers
- Threat to patient self esteem
  - Denies need for mental health services
- Insurance reimbursement issues

Lipsitt, 2005
Psychiatric Disorders
Bipolar Affective Disorder I

(≥3 if mood disturbance/increased activity; ≥4 irritability)

- **Manic Episode** (≥1 week)
  - May be preceded by or followed by a hypomanic or depressive episode
  - Elevated, expansive or irritable mood
  - Increased goal directed activity or energy

- **Impaired social/occupational functioning**

- **Not attributed to drugs, medications, treatments**

- **Manic episode**
  - Grandiosity
  - <3 hrs sleep
  - Hypertalkative
  - Flight of ideas and racing thoughts
  - Distractibility
  - Purposeless or non-directed activity
  - Increased involvement in high risk activities
  - Hallucinations
  - Suicidal ideations
Bipolar I

Not to be confused with

Borderline Personality Disorder
Borderline Personality Disorder
(5 or more)

- Pattern of instability
  - Relationships
  - Self esteem
  - Impulsivity
- Symptoms usually last a few hours to a few days
- Avoid real or imagined abandonment
- Intense interpersonal relationships

- Unstable self image
- Impulsivity
  - Spending, increased sexual behaviors, substance use, reckless
- Suicidal behaviors, gestures, threats
- Marked reactivity of mood
  - Dysphoria, irritability, anxiety
- Feelings of emptiness
- Uncontrollable anger
- Stress related paranoia, dissociative symptoms

APA, DSM V, 2013
Major Depressive Disorder
(5 or more of the following)

- Depressed mood
- Anhedonia
- Weight loss/weight gain (>5% in one month)
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue/anergy
- Feelings of guilt/worthlessness
- Decreased focus, concentration
- Indecisiveness
- Suicidal ideation
- Distress and/or impairment for 2 weeks or more
TREATMENT STRATEGIES
Depression Statistics

- 40% of patients with depression decline treatment
- Emotional issues are underreported to PCP
  - 20-30% of patients report emotional issues to PCP
- Patient somatize psychological issues
- 80% of patients with depression present with physical symptoms, i.e., pain, fatigue, worsening of chronic medical problems
- 1 in 3 patients with chest pain in the ED have panic disorder or depression

Mental Health Care Services by Family Physicians (Position Paper), 2015
Depression: Challenge for PCP

- Accurate diagnosis of Major Depression is masked by patient complaints of headaches, insomnia, fatigue, lack of appetite
- Missed in the elderly due to other illnesses having similar symptoms
  - Memory loss
  - Confusion
  - Lethargy
Treatment Resistant Depression

- Inquire about home/work
- Review medications and responses to treatment – keep journal
- Explore if and how patient is taking medications

- Consider another diagnosis
- Consider what can be worsening the depression
  - Thyroid
  - Chronic pain
  - Cardiac problems
Treatment Strategies

- Allow the medication time to work
  - 4-8 weeks
- Increase dosage
- Consider another antidepressant
- Augment medication:
  - Antipsychotic
  - Mood stabilizer
  - Anxiolytics
- Psychotherapy
- Social Service Referrals
- Referral to spiritual/religious authority
Texas Medication Algorithm Project

Stage 1
- Monotherapy
  - SSRI, BUPsr, NEF, VLFxR, or MRT

Stage 2
- Monotherapy
  - SSRI, BUPsr, NEF, TCA, VLFxR, or MRT
  - Partial Response or Nonresponse

Stage 3
- Monotherapy
  - SSRI, BUPsr, NEF, TCA, VLFxR, or MAOI*
  - From a Class Other Than Used in Stage 1 or 2

Stage 4
- Lithium Augmentation***

Stage 5
- Combination Antidepressants:
  - TCA + SSRI
  - BUPsr + SSRI
  - NEF + SSRI
  - BUPsr + NEF

Stage 6
- Electroconvulsive Therapy

Stage 7
- Other
  - eg, lamotrigine, fluvoxamine, MRT + BUP, olanzapine, etc.
  - (provide rationale)
  - If response

*This algorithm is in the public domain and may be found on the Texas Department of State Health Services Web site at http://www.dshs.state.tx.us/mhprograms/timandd/alg.pdf. For more information, see Trivedi et al. and Crismon et al.

Abbreviations: BUPsr = bupropion sustained release, MAOI = monoamine oxidase inhibitor, MRT = mirtazapine, NEF = nefazodone, SSRI = selective serotonin reuptake inhibitor (includes fluoxetine, sertraline, paroxetine, and citalopram), TCA = tricyclic antidepressant, VLFxR = venlafaxine extended release.

Symbols: * = Consider TCA or VLF if not tried, ** = Augment with lithium, thyroid hormone, or buspirone, *** = Skip if lithium augmentation has already failed, † = Most studied combination.
Future of Psychiatry

- Earlier diagnosis and intervention*
- Genetic research*
- Neuroplasticity research*
- Neurostimulation for brain repair*
- Pharmacogenomics in clinical practice*
- Linking of physical and mental disorders*
- Integration of psychiatric providers, psychotherapists into primary care facilities.

Nasrallah, 2009
References

American Academy of Child & Adolescent Psychiatry (2015). When to seek referral or consultation with a Child Adolescent Psychiatrist. Retrieved from https://www.aacap.org/aacap/Member_Resources/Practice_Information/When_to_Seek_Referral_or_Consultation_with_a_CAP.aspx


