Primary Care Psychiatry 2018

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• As we start, a question – What contributes most to premature mortality in the united states?

A. Genetic predisposition
B. Lack of health care
C. Behavior patterns
D. Social circumstances
Contribution to Premature Mortality in the United States

- Behavioral patterns: 40%
- Genetic predisposition: 30%
- Social circumstances: 15%
- Health care: 10%
- Environmental exposure: 5%

Overview

Behavioral Health (BH) = Psychiatry/Mental health

• What we will cover:
  1. Epidemiology of BH issues in Primary Care
  2. Likely future approaches to BH problems
  3. Approach to patients with BH problems in the here & now
  4. Specific BH issues:
    a. Communication, Motivational interviewing
    b. Mood disorders: Depression, Bipolar disorder
    c. Anxiety
    d. ADHD
    e. Somatic Symptom Disorder
    f. Neurocognitive Disorders (Delirium, Dementia)
    g. Substance Use Disorders
    h. Suicide

i. Not covered but important: PTSD, Eating Disorders, Personality Disorders, OCD, Psychosis
Introduction

Mental illness is largely a hidden health issue, rarely receiving public attention, underfunded, and seldom mentioned during health care discussions. **BUT It’s important:** affecting 44-60 million adults and more than 13 million children in the U.S. Only about half the adults and 1/3 of the children receive any treatment.

Of those who receive treatment, 43-52% get some of that treatment from their primary care provider; and at least 32% get all their MH treatment in primary care!

*Mental health care services by Family physicians. http://www.aafp.org/about/policies/all/mental-services.*

*Am J Psychiatry 2006; 63:1187-1198*
Where patients get care for BH problems

Primary Care, the ‘DE Facto’ Mental Health Care System in America

Wang P, et al., Arch Gen Psychiatry, 62, June 2005 (adapted)
A “hidden” issue in more ways than one.....

• Nearly ½ of the mental health problems that exist in an average primary care practice are unidentified.

(Spitzer et.al., JAMA. 1994;272:1749-156) (Prime MD 1000 study).
THE FUTURE:
What is “Integrated” Primary Care & Mental Health Care?

“...in essence integrated health care is the systematic coordination of health care for both medical and behavioral health problems. The idea being that since physical and behavioral health problems often occur at the same time, integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served.”


• You may hear terms like “Cooperative care, Co-located care, Unified or Fused Care, or Collaborative Care”; all terms to describe different degrees of the same idea.
Collaborative Care in the Real World

• **Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial.** Unützer J, et. al., *JAMA.* 2002 Dec 11;288(22):2836-45

At 12 months, 45% of intervention patients had a 50% or greater reduction in depressive symptoms from baseline compared with 19% of usual care participants (odds ratio [OR], 3.45.

• **Effectiveness of Collaborative Care for Older Adults With Alzheimer Disease in Primary Care: A Randomized Controlled Trial.** Callahan C, et.al., *JAMA.* 2006;295(18):2148-2157. doi:10.1001/jama.295.18.2148

89% of intervention patients triggered at least 1 protocol for behavioral and psychological symptoms of dementia with a mean of 4 per patient; patients more likely to get cholinesterase inhibitors, antidepressants; not more likely to get antipsychotics; and at 12 months there was significantly less caregiver distress.
Patients with behavioral health disorders treated in routine care experience worse outcomes than patients enrolled in clinical trials using evidence-based treatments. This gap is particularly apparent in the primary care treatment of such disorders.

“One of the main contributors to poor outcomes in routine care is that providers do not typically use symptom rating scales in a systematic way to determine quantitatively whether their patients are improving”.

www.thekennedyforum.org Measurement Based Care (2015)
Measurement-based care (MBC) is just clinical care based on patient data systematically collected during treatment; as applied to mental health is usually means that fairly simple scales are used on a fairly regular basis. The ones I use are all in the public domain and cost essentially nothing (cost of printing).

Every one of you believe strongly in MBC but few use it to follow patient being treated for BH issues.

Examples: High blood pressure; starting patients on dialysis; Anemia and blood transfusion; and on & on...

To be EFFECTIVE the result of the BH measurement must be delivered to you AT THE TIME OF THE VISIT!
The Joint Commission View on MBC

• “The Joint Commission... has always required organizations to assess outcomes of care, treatment, or services;...they will now be required to accomplish this through the use of a standardized tool or instrument”.
  www.jointcommission.org/assets/1/.../Revised_Outcome_Measure_.
  Accessed 8/31/2018

• “All primary care and behavioral health providers treating mental health and substance use disorders should implement a system of measurement-based care whereby validated symptom rating scales are completed by patients and reviewed by clinicians during encounters.....

Fixing Behavioral Health Care in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services. Kennedy Center Forum 2015

And does it work? “Real-world” study in 18 primary care clinics: at 8 weeks, remission in 30% (about); improvement in 50%.
• I’m here to day to deliver two messages:

• 1) That treatment of behavioral health problems in America is changing to a collaborative care model; I think that change will be fairly slow, but inevitable.

• 2) In the meantime you can deal effectively with many (if not most) of Behavioral Health issues you see by starting to provide the MBC which will eventually be a core component of Collaborative Care.

• And you do this every day…..(BP, DM,HF,CKD,etc.)
Communicating with Patients: Motivational Interviewing

Change is a process, not an event.
MI

- A Definition of Motivational Interviewing (MI)
- MI focuses on exploring and resolving ambivalence and centers on motivational processes within the individual that facilitate change.
- It’s collaborative.

The philosophy of MI can be translated into five central principles summarized by the acronym DEARS:
- Develop discrepancy
- Express empathy
- Amplify ambivalence
- Roll with resistance
- Support self-efficacy

FUNDAMENTAL SKILLS
- Open-ended Questions
- Affirmations
- Reflections
- Summarizations
Which disorder has the highest prevalence in an average primary care practice?

A. Depression
B. Anxiety disorders
C. ADHD
D. Psychosis

SOMATIC SYMPTOM DISORDER (somatoform in DSM-IV)
The Frequency of Major Mental Disorders in the United States

- As a group, anxiety disorders are the most common form of mental illness in the United States.
- Depression is the most common single disorder.
A 61-year-old woman presents to your office for the fifth visit this year with continued complaints of vague abdominal pain, headaches, intermittent nausea, constipation, and fatigue. She reports feeling “down” about her ongoing physical symptoms. In addition, she complains of some insomnia and decreased ability to enjoy her usual activities. Physical examination is unremarkable, and laboratory workup to date, including thyroid function studies, is normal. Which of the following represents the most likely diagnosis at this time?

A. Somatization disorder
B. Factitious disorder
C. Hypochondriasis
D. Depression

Suppose her PHQ9 score is 21;

And suppose she scores ‘3’ on Question 9, “Thoughts that you would be better off dead, or of hurting yourself” (nearly every day)
DEPRESSION

Overview.

- Major depression is a syndrome that is a disorder of mood involving problems in emotional, cognitive, behavioral and somatic regulation.
- Secondary if it occurs in association with drug intoxication or withdrawal, with various general medical conditions, in association with other psychiatric conditions, as a consequence of prescription medications.
- Primary if it does not occur in association with these conditions. Categorized into depressive (unipolar) and manic depressive (bipolar) conditions.
  
  Unipolar mood conditions are divided into major depressive disorder, persistent depressive disorder and depression not otherwise specified.
Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?  
2. During the past month, have you often been bothered by little interest or pleasure in doing things?
PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? (0 = not at all; 1 = several days; 2 = more than one half the days; 3 = nearly every day)

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people have noticed or the opposite (i.e., being so fidgety or restless that you have been moving around a lot more than usual)
9. Thoughts that you would be better off dead or hurting yourself in some way
10. If you have 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?
TREATMENT

SSRIs, plus Venlafaxine, duloxetine, desvenlafaxine, mirtazapine and bupropion and a couple of others – are all first line options. TCA’s and MAOI’s are best reserved for experts. (American Psychiatric Association, 2013 [Guideline]

NON-DRUG:
Behavioral Activation!!

CBT
Staring B-Activation

![Diagram showing cycle of thoughts, behaviors, and feelings]

### Positive Activities for Behavioral Activation

Create a list of activities that you find rewarding. Rate each activity in two categories: How easy the activity will be for you to complete, and how rewarding it is (with 10 being very easy or rewarding, and 1 being difficult or not at all rewarding).

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>EASE (1-10)</th>
<th>REWARD (1-10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Go for a walk.</td>
<td>9</td>
<td>6</td>
</tr>
</tbody>
</table>
### DOSING

4 weeks at Target dose is an adequate trial

#### Table. Using fluoxetine (40 mg) as the comparison value

<table>
<thead>
<tr>
<th>Antidepressant</th>
<th>Evidence-based equivalent (mg)</th>
<th>Clinically practical equivalent (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>fluoxetine</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>bupropion</td>
<td>348</td>
<td>300</td>
</tr>
<tr>
<td>paroxetine</td>
<td>34</td>
<td>30</td>
</tr>
<tr>
<td>escitalopram</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>sertraline</td>
<td>98</td>
<td>100</td>
</tr>
<tr>
<td>venlafaxine</td>
<td>149</td>
<td>150</td>
</tr>
<tr>
<td>mirtazapine</td>
<td>51</td>
<td>45</td>
</tr>
</tbody>
</table>
Depression Treatment Guides

- Psychopharmacology Algorithms from the Psychopharmacology Algorithm Project at the Harvard Medical School Dept. of Psychiatry, South Shore Program
  David N. Osser, M.D., Founder and Series Editor

- VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF MAJOR DEPRESSIVE DISORDER

- Texas Medication Algorithm Project (TMAP): Strategies for the Treatment of Nonpsychotic Major Depressive Disorder
An 82-year-old woman who has been in your practice for years comes in a follow-up visit. You have known her for years and know that her husband was being treated for metastatic lung cancer and was not responding well.

Her husband died 1 month ago and since then time, she’s been breaking down into tears frequently. She says that she hears her husband’s voice almost every night. She has decreased energy, some anhedonia, and insomnia, but she does go out to dinner with friends two to three times per week and continues to do chores around the house. She denies suicidal ideation.

Which of the following is most appropriate in her management?
A. Start low-dose fluoxetine
B. Start low-dose haloperidol
C. Refer to a psychiatrist for therapy
D. Tell her that her symptoms are typical for grief reactions and see her back in a few weeks

“This decision inevitably requires the exercise of clinical judgment”... DSM-5, page 95
Mental health problems in primary care

- Emotional symptoms are common but do not necessarily mean that the sufferer has a mental disorder.
- Many mood disorders are short lived responses to stresses in peoples' lives such as bereavement.
- About 30% of people with no mental disorder suffer from fatigue, and 12% suffer from depressed mood.
- “Should a person have to bear the ordinary pains of life, or should we allow Prozac to provide a temporary escape”? Book review of “Listening to Prozac”

Bereavement

- Death of a loved one is a distressing episode in normal human experience. Expression of distress varies greatly between individual people and cultures, and grieving does not constitute mental disorder. The doctor's most appropriate response is compassion and reassurance rather than drug treatment. Antidepressants should be reserved for those patients who develop a depressive episode.

T K J Craig, A P Boardman. BMJ 1997;314:1609
Which of the following is true? When ill,

A. Patients with true bipolar disorder spend more time in the manic phase;
B. Patients with true bipolar disorder spend more time in the hypomanic phase
C. Patients with true bipolar disorder spend more time in the depressed phase
Bipolar Disorder

- Presentation with **Depression**, not mania or hypomania is the rule! (BD-1, 3 weeks D/1 week manic) BD-2, 39 D/1 hypomanic

- Comorbidity is very common; other medical illnesses and/or alcohol and drug use obscure the diagnosis and make treatment difficult. Screen!

- Screening patients with any past or present psychiatric symptom is likely to show a prevalence of 25% or more possible cases. (John F. Chiu, Pratap R. Chokka. Can Fam Physician. 2011 Feb; 57(2): e58–e67)

- However, a systematic review with structured interviews estimated the prevalence as less than 10%. Joseph M. Cerimele, Lydia A. Chwastiak, Sherry Dodson, and Wayne J. Katon. Gen Hosp Psychiatry 10.1016/j.genhosppsych.2013.09.008

- Less than ½ the patients with Bipolar Illness come for care in the 1st year of the illness; median time to diagnosis is 6 years.

Why do patients with Bipolar Disorder Need A Primary Care Provider?

People with BD have an increased mortality compared to the general population; and the cause is....

1) Respiratory, 2) Accidents, 3) Suicide, 4) Vascular

Because of...

Metabolic syndrome

- Which is composed of several cardiovascular risk factors: visceral obesity, hypertriglyceridemia, low HDL, hypertension, and insulin resistance.
- U.S. samples indicate an elevated risk of metabolic syndrome in those with bipolar disorder, and estimates suggest a prevalence of 30% – 53% in those with bipolar disorder.

MOODCHECK Bipolar Screen

- MoodCheck
- Part A. Please place a check after the statements below that accurately describe you.
  - During times when I am not using drugs or alcohol:
    - I notice that my mood and/or energy levels shift drastically from time to time.
    - At times, I am moody and/or energy level is very low, and at other times, and very high.
    - During my "low" phases, I often feel a lack of energy, a need to stay in bed or get extra sleep, and little or no motivation to do things I need to do.
    - I often put on weight during these periods........

Sensitivity and specificity of a new bipolar spectrum diagnostic scale.
A 32-year-old nurse presents to her primary care provider complaining of frequent headaches, irritable bowel, insomnia, and depressed mood. She currently takes no medication and has no history of substance misuse or major medical problems beyond treatment for a single depressive episode when she was a college freshman. Her physical exam, routine labs, and computed tomography of the brain are all within normal limits.

Diagnosis?

Her family history is notable for several ancestors who have been affected by psychiatric illness, including depression, bipolar disorder, and schizophrenia. Her paternal grandfather and a maternal aunt committed suicide.

She’s had 3 prior episodes, each several weeks in duration, characterized by insubordinate behavior at work, irritability, high energy, and decreased need for sleep. She regrets impulsive sexual and financial decisions that she took during these episodes, and has recently filed for personal bankruptcy.

For the past month her mood has been persistently low, and she has had reductions in sleep, appetite, energy, and concentration, with some passive thoughts of suicide.
BIPOLAR DOMAINS

**Manic Mood**
- Euphoria, Grandiosity
- Pressured speech
- Impulsivity, reckless,
  decreased need for sleep,
  Libido, socially intrusive

**Depression, Anxiety,**
**Irritability, Hostility,**
**Violence, Suicide**

**Cognitive Symptoms**
- Racing thoughts
- Distractibility
- Disorganization
- Inattention

**Psychosis**
- Delusions,
  Hallucinations,
  Disorganized speech
  & behavior

Tailor your Treatment

Acute (New, recurrent)
• Severe Manic/Mixed: Lithium + Atypical or Anticonvulsant; with Mixed features Valproate may be better than Lithium. Atypicals preferred over typicals b/o fewer side effects.
• Acute Depression (w/BD): Lithium, + Lamotrigine. **Don’t use antidepressants as monotherapy!**
• Rapid cycling: Lithium or Valproate; combo’s needed; don’t use valproate and Lamotrigine!!

Maintenance
• Lithium, Valproate, Lamotrigine, Carbamazepine; Atypicals
### FDA-Approved Bipolar Treatment Regimens

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Manic</th>
<th>Mixed</th>
<th>Maintenance</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valproate</td>
<td>Depakote</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carbamazepine extended release</td>
<td>Equestro</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>Lamictal</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Lithium</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>Abilify</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>Geodon</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risperidone</td>
<td>Risperdal</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quetiapine</td>
<td>Seroquel</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>Thorazine</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olanzapine</td>
<td>Zyprexa</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Olanzapine/fluoxetine Combination</td>
<td>Symbyax</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Bipolar (BD) vs. Borderline (BPD)

- Mania is not present in BPD
- Mood in BD tends to be stable for days, months, and weeks; in BPD mood may change many times a day.
- Very often there’s a family history of BD
- Sleep patterns are pretty normal in BPD
- Relationships are unstable in BPD; not so much in BD.
- Self-injury: About 75% of patients with BPD have cut, burned, or otherwise injured themselves.
Borderline PD vs Bipolar Disorder (BD):
Watch the movie, don’t look at the snapshot!

• In a snapshot, they can look similar—both can present with impulsive behavior, intense emotions and suicidal thinking. But this snapshot is not the best way to tell them apart. It’s really the movie of the symptom presentation over time that can help make the diagnosis distinct.

• Bipolar 1 requires a manic episode for diagnosis, and is unusual in BPD. In both BD 1&2 mood episodes last days or weeks; in BPD, minutes or hours.
Anxiety Disorder

• Anxiety disorders are more prevalent as depressive disorders, cause almost as much disability, and are recognized 1/2 as often.

• 19% of 965 patients had at least 1 disorder:
  - PTSD 10%, GAD 8%, Panic 7%, Social Anxiety 6%

**Approach:** R/O medical disorders like Hyperthyroidism and substance abuse;

**Diagnosis:** Ask

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems? (Use “✓” to indicate your answer)</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

(Use “✔” to indicate your answer)

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

1. Feeling nervous, anxious or on edge 0 1 2 3
2. Not being able to stop or control worrying 0 1 2 3
3. Worrying too much about different things 0 1 2 3
4. Trouble relaxing 0 1 2 3
5. Being so restless that it is hard to sit still 0 1 2 3
6. Becoming easily annoyed or irritable 0 1 2 3
7. Feeling afraid as if something awful might happen 0 1 2 3

(For office coding: Total Score T____ = _____ + _____ + ____ )
Proven Effective Drugs

- Benzodiazepines
- Buspirone
- Tricyclic Antidepressants
- Selective Serotonin Reuptake Inhibitors
- Serotonin Norepinephrine Reuptake Inhibitors
- Pregabalin

*Non drug: CBT, Relaxation

Ginko Biloba – 4 week RCT in Germany, positive results. Problems: Purity, dosage hard to verify in the U.S. Maybe good for elderly with anxiety + some cognitive impairment.

Woelk et al, J Psych Res 2006

*Strong recommendation not to use BZO’s!
Figure 1 | Benzodiazepine & Z-Drug (BZRA) Deprescribing Algorithm

Why is patient taking a BZRA?
If unsure, find out if history of anxiety, past psychiatrist consult, whether may have been started in hospital for sleep, or for grief reaction.

- Insomnia on its own OR insomnia where underlying comorbidities managed
  For those ≥ 65 years of age: taking BZRA regardless of duration (avoid as first line therapy in older people)
  For those 18-64 years of age: taking BZRA > 4 weeks

Engage patients
(discuss potential risks, benefits, withdrawal plan, symptoms and duration)

Recommend Deprescribing

Taper and then stop BZRA
(taper slowly in collaboration with patient, for example ~25% every two weeks, and if possible, 12.5% reductions near end and/or planned drug-free days)

- For those ≥ 65 years of age
  (strong recommendation from systematic review and GRADE approach)
- For those 18-64 years of age
  (weak recommendation from systematic review and GRADE approach)
- Offer behavioural sleeping advice; consider CBT if available (see reverse)

Monitor every 1-2 weeks for duration of tapering
Expected benefits:
- May improve alertness, cognition, daytime sedation and reduce falls
Withdrawal symptoms:
- Insomnia, anxiety, irritability, sweating, gastrointestinal symptoms (all usually mild and last for days to a few weeks)

Use non-drug approaches to manage insomnia
Use behavioral approaches and/or CBT (see reverse)

Continue BZRA
- Minimize use of drugs that worsen insomnia (e.g. caffeine, alcohol etc.)
- Treat underlying condition
- Consider consulting psychologist or psychiatrist or sleep specialist

If symptoms relapse:
Consider
- Maintaining current BZRA dose for 1-2 weeks, then continue to taper at slow rate
Alternate drugs
- Other medications have been used to manage insomnia. Assessment of their safety and effectiveness is beyond the scope of this algorithm. See BZRA deprescribing guideline for details.

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John is a 20 y/o college sophomore; his parents are your patients and you’ve seen John off and on in his teens for minor illnesses and filling out forms for participation in school sports. Today he says he’s having trouble in college with concentration, focus, and organization; grades are lower than he likes. He thinks maybe he needs something to help him concentrate and says he has friends who take ADHD medicines and do well.

Which of the following should you NOT do?

A. Write a prescription for a 2 week supply of a stimulant medication to see if it helps.
B. Refer him to a psychologist for testing.
C. Give him a self-rating scale to complete so you can better assess overall function.
D. Ask for permission to discuss his early school years with his parents.
Primary Care Assessment

• Do a standard H&P, review available records

• Focus your interview on problems known to be common to Adults with ADHD: inattention, impulsiveness, restlessness, executive dysfunction, emotional dysregulation. (Kessler et.al. Am J Psychiatry. 2006;163(4):716.

• Focus particularly on impairment; symptoms w/o impairment is not a disorder!

• I recommend at least a self-report scale no matter how clear you think the diagnosis is; it will be extremely useful for follow-up, medication adjustment, therapy rec’s

• Scales supplement the evaluation and support (or don’t support) your diagnosis; don’t make the diagnosis based on a scale number

• And don’t be afraid to diagnose & ADHD; these patients, untreated, are vulnerable to fractured interpersonal relationships, career under-achievement, drug addiction, accidents, and premature death!
Primary Care Assessment

• **Adult ADHD Self Rating Scale (ASRS)v. 1.1;** 18 items based on DSM-IV; symptoms adapted to adults, measured on a five-point scale (0 = never and 4 = very often). Items 1 to 9 cover inattention; items 10 to 18, hyperactivity and impulsivity. Score comes from 1\textsuperscript{st} 6 questions; remaining 12 are looked and discussed.

• Q’s 1-6: each Q followed by 5 boxes, 2-3 shaded:
  4 marks in shaded area, probable (+) dx

• Conners’ adult ADHD rating scale (CAARS), & Wender Utah Rating Scale (short version) are recommended in Up to Date.

• ASRS WHO Screener – next:
Revised ASRS for DSM-5

The World Health Organization Adult Attention-Deficit/Hyperactivity Disorder Self-Report Screening Scale for DSM-5

Berk Ustun, Lenard A. Adler, Cynthia Rudin, et al

JAMA Psychiatry. 2017;74(5):520-526

Could be extremely useful If scoring worked out for clinical use; these Q’s reflect Executive disfunction!

1. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?
2. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?
3. How often do you have difficulty unwinding and relaxing when you have time to yourself?
4. When you’re in a conversation, how often do you find yourself finishing the sentence of the people you are talking to before they can finish it themselves?
5. How often do you put things off until the last minute?
6. How often do you depend on others to keep your life in order and attend to details?

Sensitivity, 91.4%; specificity, 96.0%, at score of >than or = 14.

Comments: Looks good but still a work in progress; top score for 1&2 =5; 4 for Q5, 3 for Q6, 2 for Q4; 24 points overall. Algorithm Scoring!
Prevalence of ADHD Among Adults


• From the National Comorbidity Survey Replication (NCS-R), estimated prevalence of adults aged 18 to 44 years with a current diagnosis of ADHD:
  – The overall prevalence of current adult ADHD is 4.4%.
  – Prevalence was higher for males (5.4%) versus females (3.2%).
  – The non-Hispanic white group (5.4%) had a higher prevalence than all other race/ethnicity groups.
• The estimated lifetime prevalence of ADHD in U.S. adults aged 18 to 44 years was 8.1%.

Treating ADHD

• Pharmacotherapy AND Psychosocial therapy

Nonstimulants

Atomoxetine (Strattera*)
• Guanfacine (Tenex, Intuniv* [extended release])
• Clonidine (Catapres, Kapvay* [extended release])
• Vayarin (omega-3 dietary supplement)

Antidepressants

• Bupropion (Wellbutrin)
• Desipramine (Norpramin)
• Imipramine (Tofranil)
• Nortriptyline (Aventyl, Pameler)
• Fluoxetine
• Venlafaxine (Effexor)?
• Duloxetine (Cymbalta)?

Stimulants FDA approved for ADHD

Methylphenidate (Ritalin)
Dexmethylphenidate (Focalin)
Mixed amphetamine salts (Adderall)
Dextroamphetamine (Adderall, Dexedrine)
Methamphetamine (Desoxyn)

Dementia

- **Prevalence:** age 65-84, 3-11%; age 85+, 25-47%
- **Burden of Illness:** Tremendous for patient and family; the cost to society is at least 172 billion dollars. Currently there are 5.3 million people in the U.S. with Dementia, and that number will double by 2030, and be about 18 million by 2050.
- **Diagnosis:** At least 60% of people diagnosed by the PCP without specialist input.
- The **WHO** says that PCP’s must take the lead in diagnosing and treating dementia; there are simply not enough specialists even if they were accessible!
**Mini-Cog:** Ask patient to remember 3 words. Say the words slowly and distinctly; ask them to repeat the words. Tell them you’ll ask them to recall the items later. (Flower, Boat, Mountain) **Then:**

3/5 is negative for Dementia.
Can be scored in different ways; I like 5 point system:
1 point for each word recalled; 1 point for clock numbers
1 Point for displaying correct time. Using 4/5 as the cut allows speculation about MCI but not validated.
Using cutoff score 26, MMSE sensitivity 18% to detect MCI; MoCA detected 90%. Mild AD group, MMSE sensitivity 78%, MoCA 100%. Specificity excellent for both MMSE and MoCA (100% and 87%).


SLUMS also good (VA)
<table>
<thead>
<tr>
<th>Agent</th>
<th>Mechanism of action</th>
<th>Starting dose (mg)</th>
<th>Target dose (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donepezil</td>
<td>Cholinesterase inhibitor</td>
<td>5 qd</td>
<td>5-10 qd</td>
</tr>
<tr>
<td>Rivastigmine</td>
<td>Cholinesterase inhibitor</td>
<td>1.5 bid</td>
<td>3-6 bid</td>
</tr>
<tr>
<td>Galantamine</td>
<td>Cholinesterase inhibitor; allosteric modulator at nicotinic receptor</td>
<td>4 bid</td>
<td>8-12 bid (16-24 qd extended release)</td>
</tr>
<tr>
<td>Memantine</td>
<td>Noncompetitive, NMDA receptor antagonist</td>
<td>5 qd</td>
<td>10 bid</td>
</tr>
</tbody>
</table>
# Pharmacologic Treatment of Problem Behaviors in Dementia

**All Off Label!**

[Duthie: Practice of Geriatrics, 4th ed.](#)

<table>
<thead>
<tr>
<th>Agent</th>
<th>Class</th>
<th>Dose range</th>
<th>Uses</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam</td>
<td>Benzodiazepine</td>
<td>0.25-2 mg/day</td>
<td>Anxiety, restlessness, insomnia</td>
<td>Sedation, ataxia, confusion</td>
</tr>
<tr>
<td>Oxazepam</td>
<td>Benzodiazepine</td>
<td>5-10 mg/day</td>
<td>Anxiety, sedation, ataxia, restlessness</td>
<td>Confusion, insomnia</td>
</tr>
<tr>
<td>Zolpidem</td>
<td>Nonbenzodiazepine hypnotic</td>
<td>5-10 mg HS</td>
<td>Insomnia</td>
<td>Sedation, confusion</td>
</tr>
<tr>
<td>Risperidone</td>
<td>Atypical antipsychotic</td>
<td>0.25-2 mg/day</td>
<td>Psychosis, agitation</td>
<td>Sedation, EPS, cerebrovascular event, hypotension</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>Atypical antipsychotic</td>
<td>5-10 mg/day</td>
<td>Psychosis, agitation</td>
<td>Sedation, EPS, cerebrovascular event, hypotension</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>Atypical antipsychotic</td>
<td>25-200 mg/day</td>
<td>Psychosis, agitation</td>
<td>Sedation, EPS, hypotension</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>Atypical antipsychotic</td>
<td>5 – 15 mg/day</td>
<td>Psychosis, agitation</td>
<td>Sedation, EPS, hypotension</td>
</tr>
<tr>
<td>Sertraline</td>
<td>Antidepressant</td>
<td>25-200 mg/day</td>
<td>Depression, anxiety, irritability</td>
<td>Loose stools, sedation</td>
</tr>
<tr>
<td>Citalopram</td>
<td>Antidepressant</td>
<td>10-40 mg/day</td>
<td>Depression, anxiety, irritability</td>
<td>Sedation</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>Antidepressant</td>
<td>15-30 mg/day</td>
<td>Insomnia, depression</td>
<td>Sedation, weight gain, anxiety</td>
</tr>
</tbody>
</table>
### Presenting Problems in Adult Primary Care

<table>
<thead>
<tr>
<th>Symptom 1</th>
<th>Symptom 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td>Back pain</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Insomnia</td>
</tr>
<tr>
<td>Headache</td>
<td>Abdominal pain</td>
</tr>
<tr>
<td>Swelling</td>
<td>Numbness</td>
</tr>
</tbody>
</table>

1. 40% of Visits
2. A biophysiological cause is found in 15% of cases!

Common symptoms in ambulatory care: Incidence, evaluation, therapy and outcome. American Journal of Medicine, 86, 262-266.)
DSM-5 Somatic Symptom Disorders (SSD)

DSM-IV-TR Somatoform Disorders
- Somatization
- Hypochondriasis
- Pain
- Dysmorphic Conversion

DSM-5 Somatic Symptom Disorders
- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Conversion Disorder
- Psychological factors affecting a medical condition
- Factitious Disorder

MAJOR FLAW in Somatoform Concept:
MUS = a Psychiatric problem
SSD in DSM5

• IN order to diagnose a Somatic Symptom Disorder, DSM-5 requires an explanation of how a symptom affects the patient emotionally (i.e. makes him depressed, anguished, irritated, etc.); (b) cognitively (i.e. rumination on the symptom, catastrophic ideas, etc.); and/or (c) behaviorally (i.e. constant medical consultations, stop working, etc.) Whether a symptom is explained or not is irrelevant to the diagnosis of SSD!

• Remember the earlier slide I showed you about Emotion and Stress; stress-related emotion can be expressed as a somatic symptom and may be transient.

SSD has a duration requirement:
“The state of being symptomatic is persistent”
(greater than 6 months)
Somatic Symptom Scale – 8

[SSS-8]

During the past 7 days, how much have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stomach or bowel problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Back pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Pain in your arms, legs, or joints</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Chest pain or shortness of breath</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Dizziness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Feeling tired or having low energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Trouble sleeping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SSS-8 Score = \_\_\_\_ + \_\_\_\_ + \_\_\_\_ + \_\_\_\_

0-3 min/none
4-7 low; 8-11 medium
12-15 hi; 16-32 very hi.
For each category ↑ there is a 53% ↑ in health care visits!
Somatic Symptom Disorder - Epidemiology

- Somatic Symptom Disorder Prevalence: Basically unknown; UpToDate estimates 4-6% in the general population and up to 17% among primary care patients. (article by J.L. Levenson, updated Jan 2018).


- 50% of patients present in primary care with physical symptoms have no diagnosable disease (some of these patients have stress-related symptoms which may not meet duration requirements or impairment requirements of DSM-5).

- Female-to-Male ratio (in SSD) is 10:1

- If SSD, symptoms usually begin in childhood, adolescence or early adulthood
Essential Treatment Approaches for Patients with Somatic Symptom Disorder
(Croicu, C., et al. 2014)

• Schedule time-limited regular appointments (e.g. 4-6 weeks) to address complaints
• Explain that although there may not be a reason for their symptoms, you will work together to improve their functioning as much as possible
• Educate patients how psychosocial stressors and symptoms interact
• Avoid comments like “Your symptoms are all psychological.” or “There is nothing wrong with you medically.”
The “Conditional Patient”

The patient is a 56-year-old White male with low back pain and a history of substance abuse (mostly alcohol and marijuana). On entering the exam room, he states: “You gotta give me some Vicodin, or I am seriously going to kill myself.”

How will you handle it?
1) Call Mobile Crisis?
2) Call Police?

OR: Separate “condition” from suicidal ideation; problem solve about a solution to his issue
Tennessee is second in the nation in prescriptions for Schedule II (oxycodone) & Schedule III (hydrocodone) narcotics.
Opioid Epidemic: A solution?

• “Despite awareness of the opioid-overdose crisis, the epidemic continues to worsen. In 2016, there were 42,249 opioid-overdose deaths in the United States, a 28% increase from the previous year.”….. “We believe there’s a realistic, scalable solution for reaching the millions of Americans with opioid use disorder: mobilizing the primary care physician (PCP) workforce to offer office-based addiction treatment with buprenorphine, as other countries have done”.

Medication Assisted Treatment (MAT): Bupe, Methadone, Naltrexone


Behavioral interventions alone have extremely poor outcomes, with more than 80% of patients returning to drug use. 2012) Journal of Addictive Diseases, 31:3, 207-225

Measure 5 year results! As in PHP’s!
“All treatments work for some people. No treatment works for everyone”
38,000,000

1) The number of uninsured children in the U.S.
2) The dollar amount of Medicaid Fraud per year in Tennessee
3) The number of persons in the U.S. with Chronic Serious Mental Illness
4) The number of people in the U.S. who drink too much

Each year AUD takes an enormous toll in terms of Human life (3rd leading lifestyle-related cause of death for the nation) as well as economic cost ($220 billion +)
AUD Treatment

• COMBINE Study: *JAMA* 2006;295 (17):2001-17
  8 Groups

• Group with medical management + naltrexone had a higher percentage of days abstinent than any group that did not also include medical management.

• Conclusion: “Naltrexone with medical management could be delivered in health care settings, thus serving alcohol-dependent patients who might otherwise not receive treatment”.
Suicide

- 8th leading cause of death in the U.S.
- 2nd leading COD among 25-34 y/o
- 3rd leading COD among 15-24 y/o
- 750,000 ER visits annually, b/o suicide attempts

Primary Care has a vital role in Prevention:
- 75% visited PCP within the year prior to death;
- 50% visited PCP within the month prior to suicide!

Nevertheless: Summary of Recommendation and Evidence

- The U.S. Preventive Services Task Force (USPSTF) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in adolescents, adults, and older adults in primary care

*Am Fam Physician. 2015 Feb 1;91(3):190F-190I*
Acutely psychotic patient

Unknown cause of psychosis, no known history

- Initiate treatment with haloperidol (PO/IM/IV): 0.5 mg to 5 mg + lorazepam (PO/IM/IV): 0.25 to 2 mg
- Consider adding benztropine (PO/IM/IV): 0.5 to 2 mg OR diphenhydramine (PO/IM/IV): 25 to 50 mg to reduce likelihood of acute dystonic reaction or other EPS
- Can also consider PO risperidone: 0.5 to 2 mg, risperidone + lorazepam (at doses listed above), olanzapine (PO/IM/SL): 2.5 mg to 20 mg, ziprasidone (IM): 10 to 20 mg

*Interventions may be repeated if clinically indicated; benztropine, 1 mg, or diphenhydramine, 25 mg, usually provide sufficient EPS prophylaxis for 12 hours

Known or suspected underlying psychotic illness

- Continue treatment with previous antipsychotic
  - OR
    - Initiate treatment with a second-generation antipsychotic:
      - PO: olanzapine: 5 to 10 mg, risperidone: 0.5 to 2 mg +/- lorazepam: 0.5 to 2 mg
      - IM: olanzapine: 2.5 to 20 mg, ziprasidone: 10 to 20 mg
    - OR
      - Haloperidol (PO/IM/IV): 0.5 to 5 mg + lorazepam (PO/IM/IV): 0.5 to 2 mg

*Interventions may be repeated if clinically indicated

If acute mania is suspected:
- Load with divalproex (Table)\textsuperscript{15,16}

Remember QTc!
END Presentation

Supplemental Slides Follow
Myths and realities: Buprenorphine

**Myth:** Buprenorphine is more dangerous than other treatments used in primary care. In fact, PCPs use treatments arguably more complicated and risky, such as titrating insulin, starting and monitoring anticoagulants, and prescribing full-agonist opioids for pain.

**Myth:** Buprenorphine is simply a “replacement” and that patients become “addicted” to it — a common belief held by some physicians, some patients, as well as family and friends of patients. But addiction is defined not by physiological dependence but by compulsive use of a drug despite harm. If relying on a daily medication to maintain health was addiction, then most patients with chronic health conditions such as diabetes, asthma, or hypothyroidism would be considered addicted.

**Myth:** Abstinence-based treatment, usually implying short-term detoxification and rehabilitation, is more effective than medication for addiction treatment. However, while there’s a strong evidence base for buprenorphine and methadone treatment, no study has shown that detoxification or 30-day rehabilitation programs are effective at treating opioid use disorder. These interventions may actually increase the likelihood of overdose death by eliminating the tolerance.

**Myth:** providing buprenorphine treatment is onerous and time consuming. “In our experience, it is no more burdensome than treating other chronic illnesses”.

**Myth:** If primary care providers simply stop prescribing so many opioids, all will be better. The opioid crisis certainly began with increased opioid prescribing but those rates have fallen since 2011 and overdose deaths have increased! Some data suggests that reducing access to frequently misused opioids results in people shifting their opioid of choice to heroin, so reducing prescribing might increase the death rate as people with opioid use disorder or untreated pain shift into the unstable, illicit drug market.

Adapted from Sarah E. Wakeman, M.D., and Michael L. Barnett, M.D
A 75-year-old man presents with symptoms that sound viral. The patient seemed apathetic, and commented that he needed to recover in time for hunting season. He was treated with decongestants and advised to rest and drink fluids.

Diagnosis?

This man killed himself about 3 weeks after this visit; his PCP shared this case at a conference to ask what he missed.

Would screening have been helpful?
Suicide Risk Management

• Use the C-SSRS or the SAMSHA Safe-T tool.
• Assess the risk and document your conclusion: High, Moderate, Low.

Make a Plan. Document!

http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=general-use.english
Columbia Suicide Severity Rating Scale
Lifetime-Recent

<table>
<thead>
<tr>
<th>Ask Questions 1 and 2</th>
<th>Lifetime</th>
<th>Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) <em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>2) <em>Have you actually had any thoughts of killing yourself?</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If YES to 2, ask questions 3, 4, 5, and 6.

If NO to 2, go directly to question 6.

3) *Have you been thinking about how you might do this?*
   E.g. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.”

4) *Have you had these thoughts and had some intention of acting on them?*
   As opposed to “I have the thoughts but I definitely will not do anything about them.”

5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*

6) *Have you done anything, started to do anything, or prepared to do anything to end your life?*
   Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

**Low Risk - Moderate Risk – High Risk**
### Step 1: Identify Risk Factors

<table>
<thead>
<tr>
<th>C-SSRS Suicidal Ideation Severity</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1) Wish to be dead</strong>&lt;br&gt;Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td></td>
</tr>
<tr>
<td><strong>2) Current suicidal thoughts</strong>&lt;br&gt;Have you actually had any thoughts of killing yourself?</td>
<td></td>
</tr>
<tr>
<td><strong>3) Suicidal thoughts w/ Method</strong> (w/no specific Plan or Intent or act)&lt;br&gt;Have you been thinking about how you might do this?</td>
<td></td>
</tr>
<tr>
<td><strong>4) Suicidal Intent without Specific Plan</strong>&lt;br&gt;Have you had these thoughts and had some intention of acting on them?</td>
<td></td>
</tr>
<tr>
<td><strong>5) Intent with Plan</strong>&lt;br&gt;Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td></td>
</tr>
</tbody>
</table>

### C-SSRS Suicidal Behavior: "Have you ever done anything, started to do anything, or prepared to do anything to end your life?"

Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

If “YES” Was it within the past 3 months?

### Current and Past Psychiatric Dx:
- Mood Disorder
- Psychotic disorder
- Alcohol/substance abuse disorders
- PTSD
- ADHD
- TBI
- Cluster B Personality disorders or traits (i.e., Borderline, Histrionic & Narcissistic)
- Conduct problems (antisocial behavior, aggression, impulsivity)
- Recent onset

### Presenting Symptoms:
- Anhedonia
- Impulsivity
- Hopelessness or despair
- Anxiety and/or panic
- Insomnia
- Command hallucinations
- Psychosis

### Family History:
- Suicide
- Suicidal behavior
- Axis I psychiatric diagnoses requiring hospitalization

### Precipitants/Stressors:
- Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated)
- Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- Sexual/physical abuse
- Substance intoxication or withdrawal
- Pending incarceration or homelessness
- Legal problems
- Inadequate social supports
- Social isolation
- Perceived burden on others

### Change in treatment:
- Recent inpatient discharge
- Change in provider or treatment (i.e., medications, psychotherapy, milieu)
- Hopeless or dissatisfied with provider or treatment
- Non-compliant or not receiving treatment
38,000,000

1) The number of uninsured children in the U.S.
2) The dollar amount of Medicaid Fraud per year in Tennessee
3) The number of persons in the U.S. with Chronic Serious Mental Illness (all types).
4) The number of people in the U.S. who drink too much

Only 1 in 6 people talk with a health professional about drinking

25% Alcohol screening and brief counseling can reduce the amount consumed on an occasion by 25% in those who drink too much.
Alcohol Use and Health

• 88,000 deaths attributable to excessive alcohol use each year in the United States.
• Alcohol use is the 3rd leading lifestyle-related cause of death for the nation.
• In 2006, there were more than 1.2 million emergency room visits due to excessive drinking.
• The economic costs of excessive alcohol consumption in 2006 were estimated at $223.5 billion.

SAMHSA

Accessed December 10, 2013
Measurement Tools

Examples

• PHQ and GAD-7 Screeners
• MDQ
• Geriatric Depression Scale (GDS)
• Montreal Cognitive, SLUMS (VA)
• AD8 (knowledgeable informant inventory)
• CAGE, AUDIT

Table 1. Examples of Instruments Assessing Opioid and Nonopioid Risk

<table>
<thead>
<tr>
<th>Category</th>
<th>Items, No.</th>
<th>Administered By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients considered for long-term opioid therapy:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORT: Opioid Risk Tool</td>
<td>5</td>
<td>Patient</td>
</tr>
<tr>
<td>SQAPP**: Screener and Opioid Assessment for Patients with Pain</td>
<td>24, 14, and 5</td>
<td>Patient</td>
</tr>
<tr>
<td>SISAP: Screening Instrument for Substance Abuse Potential</td>
<td>5</td>
<td>Patient</td>
</tr>
<tr>
<td>DIRE: Diagnosis, Intractability, Risk, and Efficacy Score</td>
<td>7</td>
<td>Clinician</td>
</tr>
<tr>
<td>Assess misuse once opioid treatment initiated:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDUQ-p: Prescription Drug Use Questionnaire-patient</td>
<td>31</td>
<td>Patient</td>
</tr>
<tr>
<td>COMM: Current Opioid Misuse Measure</td>
<td>17</td>
<td>Patient</td>
</tr>
<tr>
<td>PMQ: Pain Medication Questionnaire</td>
<td>26</td>
<td>Patient</td>
</tr>
<tr>
<td>PADT: Pain Assessment and Documentation Tool</td>
<td>41</td>
<td>Clinician</td>
</tr>
<tr>
<td>ABC: Addiction Behavior Checklist</td>
<td>20</td>
<td>Clinician</td>
</tr>
<tr>
<td>Nonopioid general substance abuse:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAGE-AID: Cut Down, Annoyed, Guilty, Eye-Opener Tool, Adjusted to Include Drugs</td>
<td>4</td>
<td>Clinician</td>
</tr>
<tr>
<td>RAFFT: Relax, Alone, Friends, Family, Trouble</td>
<td>5</td>
<td>Patient</td>
</tr>
<tr>
<td>DAST: Drug Abuse Screening Test</td>
<td>28</td>
<td>Patient</td>
</tr>
<tr>
<td>SBIRT: Screening, Brief Intervention, and Referral to Treatment</td>
<td>Varies</td>
<td>Clinician</td>
</tr>
<tr>
<td>AUDIT-C: Alcohol Use Disorders Identification Test: Consumption</td>
<td>3</td>
<td>Patient</td>
</tr>
<tr>
<td>DUDIT-E: Drug Use Disorders Identification Test: Extended</td>
<td>54</td>
<td>Patient</td>
</tr>
</tbody>
</table>
Substance Use Disorders
Screening

• Screen for opiate/other drug use?
  – **USPSTF** says no good evidence either way
• Screen for alcohol use?
  – **USPSTF** says yes:
    “How many times in the past year have you had 5 [for men] or 4 [for women and all adults older than 65 years] or more drinks in a day?”; if any times, follow with AUDIT, or AUDIT-C (shorter)

Treatment:
1) Motivational Interviewing techniques;
2) Consider Natrexone or Acamprosate;
3) Refer to AA or other mutual help organization. Consider referral to alcohol treatment program.

• **Treatment study outcome favoring PC – ref’s**
Is Prescription Drug Abuse in TN a problem?

• The top three most prescribed controlled substances in Tennessee in 2010:
  
  • 275.5 million pills of hydrocodone (e.g., Lortab, Lorcet, Vicodin)
  
  • 116.6 million pills prescribed of alprazolam (Xanax)
  
  • 113.5 million pills prescribed of oxycodone (e.g., OxyContin, Roxicodone)

ABOUT 40 HYDRO’s per person
Ah, Pogo, the beauty of the forest primeval gets me in the heart.

It gets me in the feet, Porkypine.

It is hard walkin' on this stuff.

Yep, son, we have met the enemy and he is us.
Diversion?

Street Value

- Oxycontin 80 mg #300 $24,000.00
- Roxicodone 30 mg #400 $12,000.00
- Dilaudid 8 mg #370 $37,000.00
- Demerol 25 mg #60 $1,500.00
- Xanax 2 mg #120 $240.00

- Assuming $1.00/mg- conservative street value= $74,740.00/month
Resilience

“Building life skills prepares individuals to successfully tackle every day challenges and adapt to stress and adversity. Life skills include coping and problem-solving skills, emotional regulation, conflict resolution, and critical thinking. Life skills are important in protecting individuals from suicidal behaviors”

“Depression and anxiety produce characteristic ways of thinking, with more negative appraisal associated with anxiety and depression”

Your Relationship with the Patient

4 E’s:

Engagement: Know the patient as a person

Empathy: Let the patient know you understand their situation; try to walk in their shoes. Not at all the same as sympathy. Empathy is Energizing!

Enlistment: Try to get the patient involved in their own health care.

Education: Don’t forget functional illiteracy and illness stress. Involve family members in the plan, use printed material and pictures

USE ORTHO SURG: skeptic to evangelist
BATHE patients in distress!

B ackground—Ask the patient to describe the situation in a few sentences. Do not ask for more detail at this point. The details are not important!

A ffect—How does the situation make the patient feel? If necessary, help them name an emotion (sad, angry, anxious, etc.).

T roubles—What troubles the patient the most about the situation? This is the real reason behind the emotion. It is often not what you expect—that’s why you have to ask!

H andling—How is the patient handling it? How has the patient handled similar (or equally bad) circumstances in the past? Are there options that the patient has not yet considered? Help the patient identify at least one positive step they can take to respond to the situation.

E mpathy—Instill hope by expressing your understanding of what the patient is going through. Reinforce the patient’s plan to deal with the problem.


(This version after Richard Rathe MD)
DSM Criteria

Diagnosis of Depression: SIG E CAPS

- 1 or 2 major symptoms (Anhedonia and/or Dysphoria)¹
- plus 3 or 4 minor symptoms (SIG E CAPS)²

Sleep ↑ ↓
Interest ↓
Guilt ↑
Energy ↓
Concentration ↓
Appetite ↑ ↓
Psychomotor ↓
Suicide ↑

“AD to SIG E CAPS for depression”

5 high yield questions-
ASK:

1. Have you ever had a panic attack? A wave of extreme anxiety and fear of dying out of nowhere?
2. Are you a worrier, a “worry wart”? How many hours a day do you worry?
3. When you’re out in public do you think people may be watching you to judge or criticize you, or do you worry you will say or do something embarrassing?
4. Has anything terrible ever happened to you that you just can’t get over and it still haunts you so that memories or feelings intrude into your mind?
5. Do you sometimes have to do things like counting or washing you hands or checking something over and over **to relieve anxiety**?

Heidi Combs MD
GAD: Seldom Without Company

Medical
- Heart disease, Diabetes, Thyroid disease, Respiratory disorders, COPD, Asthma;
- Drug misuse or withdrawal
- Withdrawal from alcohol, anti-anxiety medications (benzodiazepines) or other medications
- Chronic pain or irritable bowel syndrome
- Rare tumors that produce certain fight-or-flight hormones
- Sometimes anxiety can be a side effect of certain medications

Psychiatric
- Depression, Bipolar Disorder, Schizophrenia, Neurocognitve Disorders, SSD,
Essential Treatment Approaches for Patients with Somatic Symptom Disorder
(Croicu, C., et al. 2014)

- Case management to minimize economic impact
- Medications to treat anxiety and depression (SSRIs)
- Short term use of anxiety meds (dependence is a risk)
- Non-pharmacological treatments
  - *CBT – Shows promising evidence
  - Psychodynamic therapy
  - Integrative therapy
Emotion

Mental health problems in primary care

- Emotional symptoms are common but do not necessarily mean that the sufferer has a mental disorder.
- Many mood disorders are short-lived responses to stresses in people's lives, such as bereavement.
- About 30% of people with no mental disorder suffer from fatigue, and 12% suffer from depressed mood.
- “Should a person have to bear the ordinary pains of life, or should we allow Prozac to provide a temporary escape?” Book review of “Listening to Prozac.”

Bereavement

- Death of a loved one is a distressing episode in normal human experience. Expression of distress varies greatly between individual people and cultures, and grieving does not constitute mental disorder. The doctor's most appropriate response is compassion and reassurance rather than drug treatment. Antidepressants should be reserved for those patients who develop a depressive episode.
Critical feature of the change from DSM-IV to DSM-5

The diagnosis of somatic symptom disorder is established when three criteria are met: **distressing and impairing somatic symptoms are present; the symptoms are persistent (i.e., >6 months); and the symptoms are associated with abnormal and excessive thoughts, feelings, and behaviors**, typically manifested by disproportionate catastrophizing, high levels of anxiety, and illness behavior.

For example, following an uncomplicated myocardial infarction, a man is advised to resume normal activities, but he **worries** constantly about a recurrence and **experiences dizziness, dyspnea, and palpitations unrelated to exertion**, he restricts his activities, and he checks his pulse hourly. Note that the diagnosis of somatic symptom disorder in this case is **based on criteria that are present rather than lack of explanation of symptoms**.

In the absence of abnormal thoughts, feelings, and behaviors, patients with irritable bowel syndrome, chronic fatigue, or fibromyalgia would not qualify for a diagnosis of somatic symptom disorder.
Evidence for MAT

Primary care-based buprenorphine taper vs maintenance therapy for prescription opioid dependence: a randomized clinical trial.
CONCLUSIONS AND RELEVANCE:
• Tapering is less efficacious than ongoing maintenance treatment in patients with prescription opioid dependence who receive buprenorphine therapy in primary care.


Effectiveness of Injectable Extended-Release Naltrexone vs Daily Buprenorphine-Naloxone for Opioid Dependence: A Randomized Clinical Noninferiority Trial.
CONCLUSIONS AND RELEVANCE:
• Extended-release naltrexone was as effective as buprenorphine-naloxone in maintaining short-term abstinence from heroin and other illicit substances and should be considered as a treatment option for opioid-dependent individuals.
A 76-year-old woman is brought to you by her children because she is becoming more forgetful. She used to pay her bills independently and enjoyed cooking but has recently received overdue notices from utility companies and found it difficult to prepare a balanced meal.

She has lost 3.5 kg in the past 3 months, and left the water running in her bathtub and flooded the bathroom. When her children express their concerns, she becomes irritable and resists their help. Her house has become more cluttered and unkempt.

On a past visit to her physician, she had normal laboratory tests for metabolic, hematologic, and thyroid function.

The current evaluation reveals no depressive symptoms and 2/15 on the Geriatric Depression Scale short-form. Her Mini-Mental State Examination (MMSE) score is 20/30.
DSM-5: Dementia is in the Neurocognitive Disorder section *SELF-STUDY

Learning & Memory.
Free recall; cued recall;
Long term memory: Facts, Events
Implicit learning

Language
Word finding; Object naming
Fluency; Grammar,
Receptive language

Perceptual Motor Fctn
Visual perception; P-M coord;
Visio- spatial reasoning

Executive Function
Planning; Inhibition; Flexibility;
Decisions; Working memory;
Respond to feedback

Complex ATTn
Sustained attn; Divided attn;
Selective attn; Process speed

Social Cognition
Recognition of Emotion
Theory of mind; Insight

NeuroCognitive Domains

REF!
Learning to Speak Alzheimer’s

A Groundbreaking Approach for Everyone Dealing with the Disease

Joanne Koenig Coste

Foreword by Robert N. Butler, M.D.

“Promises to transform not only the lives of patients but those of care providers... This book is a gift.” — Sue Levkoff, coauthor of Aging Well
END