Managing Mental Illness in the Primary Care Setting

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Disclosure

• No conflicting relationships to disclose.

Overview

• Introduction and historical perspective
• Treating mood disorders
• Treating anxiety disorders
• Treating attention disorders
• Dealing with suicide
INTRODUCTION AND HISTORICAL PERSPECTIVE
What is Mental Illness?

A substantial disorder of thought, mood, perception, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life

Major Mental Illnesses

• A. Mood disorders: depression and mania
• B. Psychotic disorders: schizophrenia
• C. Anxiety Disorders
• D. Adjustment Disorders
• E. Substance Use Disorders
• F. Personality Disorders
• G. Behavior or mood problems caused by other neurological or medical illness
Neurotransmitter Systems

• Norepinephrine: Involved in mood, attention, and anxiety. Also regulates blood pressure and involved in metabolism and pain sensation.
• Serotonin: Involved in mood, anxiety, obsessive thinking. Also involved in sleep, inflammation, appetite, digestive function, nausea, yawning, and sexual performance.
• Dopamine: Involved in psychosis. Also involved in movement control, memory, addictions, and concentration.

Neurotransmitter Systems (cont.)

• Acetylcholine: Involved in memory. Also involved in movement control, anxiety, autonomic nervous systems control.
• GABA: Involved in anxiety and sleep. Also involved in addictions.
Mental Illness in the Primary Care Office

• Many patients present with psychiatric complaints along with their medical problems.
• Often you are the first point of contact for initiating therapy.
• Patients may fear stigma and may feel more comfortable being treated by a Primary Care provider.
• Patients may not have the funds to see multiple different providers.

Treatment Suggestions

• Contained in this talk are my usual treatment suggestions for various disorders.
• All recommendations are FDA approved for the specific disease, except where indicated.
• These guidelines aren’t exhaustive, refer standard sources for more complete lists/guidelines for additional options.
• Recommendations are arranged as follows: first stage for new onset problems, second stage for patients already on existing therapy, third stage for complex patients.

TREATING MOOD DISORDERS
Depression Facts

• 5-11% of the population annually is depressed.
• Suicide is the 7th leading cause of death in the US.
• Of patients with untreated MDD, 15% will die of suicide.
• Morbidity is comparable to angina and advanced coronary artery disease.
• 70% of people who commit suicide have seen their primary care MD within the prior 6 weeks.

Risk Factors for Depression

• 2:1 Female:Male.
• Peak age of onset 20-40 with another increase after age 60.
• 3X higher risk with family history of MDD.
• Separated and Divorced-higher risk.
• Married Males<Unmarried Males.
• Married Females>Unmarried Females.

Mood disorders

• Depression can occur in
  – Major depressive disorder (15-20% of pop)
  – Bipolar affective disorder (2% of pop)
  – Brain injury or degeneration
  – Drug induced mood disorder
  – Schizophrenia (depression in >50% of cases)
Depression and Mania

- **Depression**
  - Low mood disproportionate to circumstances
  - Sad facial expression, voice, posture
  - Anhedonia
  - Cognitive distortions - negative bias, including low self-esteem, guilt, hopelessness, suicidal thought
  - Somatic symptoms (loss of sleep, appetite, libido)
  - Sometimes associated with psychomotor poverty

- **Mania**
  - Euphoric or irritable mood
  - Animated/hyperactive
  - Elevated self-esteem and optimism
  - Racing thoughts
  - Impulsivity
  - Grandiosity
  - Decreased need for sleep
  - Often associated with psychomotor agitation

Mood Disorders: The Ingredients

*Hypomania is a milder form of mania with similar yet less severe symptoms and less overall impairment.*

†Mixed Episode is an episode that simultaneously presents symptoms of both depression and mania

Bipolar Disorder Is Frequently Misdiagnosed

- Only 1 in 5 patients with bipolar disorder is correctly diagnosed by a physician
  - Those incorrectly diagnosed are likely to be more impaired, female, and poorer
  - Delay of treatment may reduce the efficacy of certain pharmacological agents (eg, lithium)
- 1 in 3 is misdiagnosed as having unipolar depression, perhaps due to the prevalence of the depressive phase of the illness

*These data are based on MDQ positive scores, not clinical diagnosis of bipolar disorder


Clues That “Unipolar” Depression May Be Bipolar Depression

- Early age of onset
- Postpartum mood disorders
- Seasonal mood changes
- Hypersomnia and/or psychomotor slowing
- Severe anhedonia
- Depression with catatonia and/or psychotic features
- Bipolar family history
- Pharmacological-induced mania or hypomania
- History of recurrent but brief depressive episodes


Screening Tools: The Mood Disorder Questionnaire

Important symptoms:
- Hyper or more energetic than usual
- Predominately or thematically irritable
- Distinctly self-confident, positive or self-assured
- Less sleep than usual
- More talkative or speaking faster than usual
- Racing thoughts
- Easily distracted
- Problems at work and socially
- More interest in sex
- Taking unusual risks
- Excessive spending
Mania: 2 Quick Questions

• Have you ever had 4 continuous days when you were feeling so good, high, or “hyper” that other people thought you were not your normal self or you got in to trouble?

• Have you experienced 4 continuous days that you were so irritable that you found yourself shouting at people or starting fights or arguments?


Differentiation of Bipolar Disorder and ADHD

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Treating Unipolar vs. Bipolar Depression

• Treatment regimens differ for unipolar vs. bipolar patients.

• Important to recognize bipolar diagnosis and initiate patients on mood stabilizers.

• Antidepressants can lead to agitation, anxiety, panic attacks, irritability, erratic behavior.

• Antidepressants can induce mania, mixed states, rapid-cycling.

• Antidepressants may increase the risk of suicidality.
Suicide Attempts in Mood Disorders

- Rates of suicide attempts differ for the major mood illnesses
- Underdiagnosis and undertreatment of bipolar disorder are associated with increased risk of suicide
- Unipolar depression (n=1,214) 13%
- Bipolar I disorder (n=606) 17.5% (p<0.01 vs unipolar)
- Bipolar II disorder (n=253) 24% (p<0.001 vs unipolar and p<0.02 vs bipolar I)


Treatment of Depression/Anxiety

- First stage: SSRi of choice
- My preference for outpatients: Citalopram 20-40mg QD or Escitalopram 10mg QD
- Second stage: SNRI (Venlafaxine 150mg or Duloxetine 60mg) or Buproprion (300mg) for lethargic depression, Mirtazapine (30mg) for agitated depression/insomnia
- Third stage: combination of Mirtazapine (30-45 mg) and either Fluoxetine (20mg) or Buproprion (200-300mg), OR augment with Quetiapine, Aripiprazole, Cytomel, Deplin, Lithium, OR combination agent such as Olanzapine/Fluoxetine or Amoxapine.

Treatment of Depression (cont.)

- Remember to treat with a minimally effective dose for at least 6 weeks and preferably 12 weeks.
- You can use dose increases to keep patients in treatment.
- Consider pushing antidepressants to the maximum dose tolerated prior to switching or augmenting.
Minimum/Maximum doses for select antidepressants as monotherapy

• Fluoxetine 20mg/60mg.
• Sertraline 100mg/200mg.
• Paroxetine 20mg/60mg.
• Bupropion 300mg/450mg.
• Mirtazapine 30mg/60mg.
• Venlafaxine 150mg/375mg.
• Duloxetine 60mg/120mg.
• Citalopram 20mg/60mg.

Pharmacologic treatment of bipolar disorder

• Antipsychotics (which block dopamine): effective in treating psychomotor excitation and reality distortion during acute episodes of mania.

• Mood stabilizers (eg Lithium, and various anticonvulsants).

• Antidepressants have a limited role as they promote mania.

• Good evidence for combining an antidepressant with an atypical antipsychotic for bipolar depression.

Treatment of Bipolar Mania

• First stage: Mood stabilizer (Divalproex or Lithium) or second generation atypical of choice.

• My preference: Divalproex ER 20mg/kg QAM or Quetiapine XR 300mg QHS.

• Second stage: Mood stabilizer plus second generation atypical.
Treatment of Bipolar Depression

- First stage: Quetiapine or Olanzapine/Fluoxetine or Amoxapine.
- My preference: Quetiapine XR (150mg day 1, 300mg day 2-target dose)
- Second stage: Lamotrigine (25mg QAM 2 weeks, then 50mg X 2 weeks, then 100mg X 2 weeks, then 200mg-target dose) (FDA approved for maintenance only)
- Avoid SSRI/SNRIs except in rare cases
- May use Mirtazapine 30mg QHS instead (not FDA approved for bipolar disorder)

Treatment of Bipolar Mania

- First stage: Mood stabilizer (Depakote or Lithium) or second generation atypical of choice.
- My preference: Depakote ER 1000mg QAM.
- Second stage: Mood stabilizer plus second generation atypical.

Treatment of Bipolar Depression

- First stage: Quetiapine or Olanzapine/Fluoxetine.
- My preference: Quetiapine rapid taper (50mg QHS day 1, 100mg day 2, 200mg day 3, 300mg day 4-target dose)
- Second stage: Lamotrigine (25mg QAM 2 weeks, then 50mg X 2 weeks, then 100mg X 2 weeks, then 200mg-target dose) (FDA approved for maintenance only)
- Avoid SSRI/SNRIs except in rare cases
- May use Mirtazapine 30mg QHS instead (not FDA approved for bipolar disorder)
Side Effects of SSRI Antidepressants

These are the most common antidepressants prescribed because:
- They are not lethal in overdose.
- They are relatively easy to dose.
- They have fewer drug interactions.
- They have fewer side effects than TCAs.
- They have no diet restriction like MAO-Is.
- They have no laboratory/blood level requirements.

Side Effects of SSRIs (cont.)

Common side effects of SSRIs include:
- Headache
- Nausea/vomiting
- Appetite increase/decrease
- Sleep increase/decrease
- Sexual dysfunction
- Weight gain
- Dry mouth

Antidepressant Discontinuation Syndrome

Remember FLUSH
- F-flu-like symptoms
- L-lightheadedness or dizziness
- U-upset stomach
- S-sensory phenomena (itching, crawling skin, etc.)
  and sleep disturbance (insomnia, nightmares)
- H-headaches
- May take weeks to resolve and may require slow weaning of the drug
TREATING ANXIETY DISORDERS

Anxiety

- Feeling of unease, dread, fear together with symptoms reflecting over-activity on the sympathetic nervous system
  - Generalised anxiety disorder
  - Panic disorder - brief dramatic episodes
  - Specific phobias eg. fear of spiders
  - Agoraphobia - fear of public places
  - Post-traumatic stress disorder
  - Obsessive-compulsive disorder
- Anxiety disorders frequently coexist, and are often associated with depression

PTSD: Critical Incident Facts

- Over 80% of US citizens will be exposed to some type of trauma.
- Around 9% of those people will develop PTSD.
- So, in general exposure to some type of trauma is “common” but developing PTSD is “uncommon”.
- 2.8 million Americans are Vietnam Veterans.
- Between 500,000 and 1.5 million Vietnam Veterans have PTSD, or 18-54%.

PTSD: Critical Incident Facts (cont.)

- Exposure to Critical Incidents/Trauma leads to some stress for most people.
- Stress reactions are a Normal Response of Normal People to an Abnormal Event.
- Failure of coping mechanisms can lead to stress that persists long after the incident.

Pharmacotherapy of PTSD/Anxiety disorders

- SSRIs:
  - Treatment of choice for most patients
  - No addiction/abuse potential
  - Long term efficacy data
- Benzodiazepines:
  - Klonopin, Valium, Ativan, etc.
  - Quick onset of action, but efficacy may wane over time
  - Significant abuse potential
- Beta-blockers:
  - Inderal, etc.
  - Some good data in decreasing frequency/intensity of nightmares, flashbacks
  - Some usefulness in restructuring memory (see below)
- Other treatments:
  - Gabapentin—good substitute for benzodiazepines; for many patients
  - Hydroxyzine—good substitute for antidepressants for select patients
  - Prazosin/Doxazosin—good for nightmares, flashbacks, impulsivity and some anxiolytic potential
  - Memantine—spare patients important for panic disorder and no abuse potential
  - Some antipsychotics—some data to support both 10 mg zolpidem (Ambien) and buspirone for PTSD/Anxiety

Treatment of Anxiety

- First stage: SSRI of choice.
- My preferences: Citalopram 20-40mg QD or Paroxetine 20-40mg QHS
- Second stage: different mechanism antidepressant such as Mirtazapine 15-30mg QHS or Tricyclic antidepressants such as Amitryptyline (50-200mg QHS)
- Third stage: anticonvulsant Gabapentin (300mg BID-QID) or Propranolol (10mg once/twice daily)
- PRN treatment: Hydroxyzine (25-50mg q6-8-hours prn).
- NOTE: all treatment except SSRIs is off label.
- Avoid benzodiazepines except in extraordinary circumstances.
Treatment of PTSD

• First stage: SSRI of choice.
  • My preferences: Citalopram 20-40mg QD or Paroxetine 20-40mg QHS
• Second stage: different mechanism antidepressant such as Mirtazapine 15-30mg QHS or Tricyclic antidepressants such as Amitryptiline (50-200mg QHS)
• Third stage: atypical such as Quetiapine (100-300mg QHS) or anticonvulsant Divalproex (20mg/kg) or Guanfacine/Clonidine
• NOTE: all treatment except SSRIs is off label.

TREATING ATTENTION DISORDERS

Symptoms of Attention Deficit Disorders

• Problems with attention including being often easily distracted by extraneous stimuli.
• Often makes decisions impulsively.
• Often has difficulty stopping activities or behavior needed.
• Often starts a project or task without reading or listening to directions carefully.
• Often shows poor follow through on promises or commitments made to others.
• Often has trouble doing things in their proper order or sequence.
• Often is more likely to drive a motor vehicle much faster than others.
• Often has difficulty engaging in leisure activities or doing fun things quietly
• Often has difficulty sustaining attention in tasks or leisure activities
• Often has difficulty organizing tasks and activities.
• Some symptoms that caused impairment were present before age 16 years.
  Impairment from the symptoms is present in two or more settings (e.g., work, educational activities, home life, social functioning, community activities, etc.).

Russell Barkley, PhD, private communication used with permission.
Key points when seeing patients seeking ADHD treatment

- Symptoms must have been present prior to age 16.
- Symptoms must impair multiple aspects of functioning.
- Be cautious in the face of other psychiatric diagnoses or substance abuse.
- When in doubt, refer for further evaluation.
- Always attempt to couple medication interventions with psychotherapy/behavioral interventions.

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Pharmacotherapy of ADHD

- Stimulants:
  - Amphetamines/dextroamphetamine (Adderall and Adderall XR)
  - Modafinil (Provigil)
- Methylenedihydroxy (Methylphenidate) (Ritalin)
- Atypical stimulants:
  - Modafinil
- Norepinephrine reuptake inhibitors:
  - Atomoxetine (Strattera)
- Other agents:
  - Guanfacine (Tenex, Intuniv)
  - Clonidine (Catapres)
  - Methobammin/methylfolate with N-acetylcysteine (Cerefolin-NAC)
  - Buproprion
  - Coenzyme Q10
- Consider Aripiprazole (Abilify) or Brexpiprazole (Rexulti)
Treatment of ADHD

• First stage: stimulant of choice.
  My preferences: Lisdexamphetamine 40-70mg QAM, or Amphetamine/dextroamphetamine 15-30mg QAM.

• Second stage: different mechanism
  Methylphenidate-based stimulant OR Atomoxetine OR Guanfacine/Clonidine OR Buproprion.

• Third stage: combination of either Amphetamine or Methylphenidate medication with Guanfacine or Clonidine.

DEALING WITH SUICIDE

National Statistics

• One person dies by suicide every 16.6 minutes and every year over 32,000 Americans die by suicide, approximately 90 people per day.
• Suicide is the 11th leading cause of death.
• It is the third leading cause of death for individuals between the ages of 15 and 24.
• There is one suicide attempt every 39 seconds and 750,000 - 1.2 million attempts each year.
• It is estimated that the cost of self-inflicted injuries and suicide is over $33 billion per year.
• Over 90% of suicide victims have a significant psychiatric illness or substance abuse disorder at the time of their death. These are often undiagnosed, untreated or both.

National Statistics

- Research suggests that 20% - 50% of individuals who die by suicide have alcohol or drug use problems.
  - Thus, substance use disorder is the psychiatric diagnosis with the second greatest association to suicide, second only to depression. Suicide prevention initiatives that identify at-risk populations and provide treatment must target people with both mental illness and/or substance use disorders, as both are associated with an increased risk of suicide.
- Research shows that during our lifetime 20% of us will have a suicide within our immediate family, and 60% of us will personally know someone who dies by suicide.

Death by Suicide and Psychiatric Diagnosis

Psychological studies done in various countries from over almost 50 years report the same outcomes. 
- 90% of people who die by suicide are suffering from one or more psychiatric disorders:
  - Major Depressive Disorder
  - Bipolar Disorder, Depressive Phase
  - Alcohol or Substance Abuse
  - Schizophrenia
  - Personality Disorders such as Borderline Personality Disorder

Risk Factors for Suicide

- Psychiatric illness diagnosed.
- Poor compliance with treatment.
- Family history of suicide in blood relatives.
- Personally knowing someone who committed suicide.
- History of abuse: physical, sexual, emotional, neglect.
- Acute/severe medical illness or pain.
- Acute stress: loses or grief.
- Chronic stress: perceived uselessness, not feeling needed, burden to extended kin.
- History of excessive introversion.
- Dissatisfaction with present life.
- Lack of hope for the future.
Risk Factors for Suicide (cont.)

- Current substance abuse.
- Past history of suicidal acts/gestures.
- Lack of religious beliefs.
- Acute stress: rejection.
- Chronic stress: lack of positive relationships, social isolation.
- History of excessive extroversion and impulsive behaviors (including rage, anger, physical fights, seeking revenge).
- Lack of coping skills (cracks under pressure).
- Lack of children.
- History of command hallucinations of self-directed violence.
- Age: Older than 60 or Younger than 25.
- Male gender.

Factors Highly Correlated with Suicide Completers

- Acute stress: loses or grief.
- Dissatisfaction with present life.
- Lack of hope for the future.
- Current substance abuse.
- Lack of coping skills (cracks under pressure).

Myth vs. Fact

**Myth:** People who talk about suicide don’t die by suicide.
**Fact:** Many people who die by suicide have given definite warnings to family and friends of their intentions. Always take any comment about suicide seriously.

**Myth:** Suicide happens without warning.
**Fact:** Most suicidal people give many clues and warning signs regarding their suicidal intention.
Myth vs. Fact

Myth: People who are suicidal are fully intent on dying.
Fact: Most suicidal people are undecided about living or dying—which is called suicidal ambivalence. A part of them wants to live; however, death seems like the only way out of their pain and suffering. They may allow themselves to “gamble with death,” leaving it up to other to save them.

Myth: Males are more likely to be suicidal.
Fact: Men die by suicide more often than women. However, women attempt suicide three times more often than men.


Myth vs. Fact

Myth: Asking a depressed person about suicide will push him/her to kill themselves.
Fact: Studies have shown that patients with depression have these ideas and talking about them does not increase the risk of them taking their own life.

Myth: Improvement following a suicide attempt or crisis means that the risk is over.
Fact: Most suicides occur within days or weeks of “improvement” when the individual has the energy and motivation to actually follow through with his/her suicidal thoughts.

Myth vs. Fact

Myth: Once a person attempts suicide the pain and shame will keep them from trying again.
Fact: The most common psychiatric illness that ends in suicide is major depression, a recurring illness. Every time a patient gets depressed, the risk of suicide returns.

Myth: Suicide occurs in great numbers around holidays in November and December.
Fact: Highest rates of suicide are in April while the lowest rates are in December.

Show You Care

- Take ALL talk of suicide seriously. If you are concerned that someone may take their life, trust your judgment.
- Listen carefully.
- Reflect what you hear.
- Use language appropriate for the age of the person involved.

Getting Help

- Do not leave the person alone
- Know referral resources
- Reassure the person
- Encourage the person to participate in the helping process
- Encourage the suicidal person to identify other people in their lives who can also help.
- Outline a safety plan: Make arrangements for the helper to come to you OR take the person directly to the source of help. Once therapy (or hospitalization) is initiated, be sure the suicidal person is following through with appointments and medications.

Conclusion

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