Psychiatric consultation in the collaborative care model: The “bipolar sieve” effect

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A B S T R A C T

Around the world, psychiatrists are in exceptionally short supply. The majority of mental health treatment is delivered in primary care. In the United States, the Collaborative Care Model (CCM) addresses the shortfall of psychiatrists by providing indirect consultation in primary care. A Cochrane meta-analysis affirms the efficacy this model for depression and anxiety. However, our experience with the CCM suggests that most patients referred for consultation have problems far more complex than simple depression and anxiety. Based on preliminary data, we offer five linked hypotheses: (1) in an efficient collaborative care process, the majority of mental illnesses can be handled by providers who are less expensive and more plentiful than psychiatrists. (2) A majority of the remaining cases will be bipolar disorder variations. Differentiating these from PTSD, the most common alternative or comorbid diagnosis, is challenging and often requires a psychiatrist’s input. (3) Psychiatric consultants can teach their primary care colleagues that bipolar diagnoses are estimations based on rigorously assessed probabilities, and that cases fall on a spectrum from unipolar to bipolar. (4) All providers must recognize that when bipolarity is missed, antidepressant prescription often follows. Antidepressants can induce bipolar mixed states, with extreme anxiety and potentially dangerous impulsivity and suicidality. (5) Psychiatrists can help develop clinical approaches in primary care that identify bipolarity and differentiate it from (or establish comorbidity with) PTSD; and psychiatrists can facilitate appropriate treatment, including bipolar-specific psychotherapies as well as use of mood stabilizers.

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Introduction

Seeking treatment for a mental illness is still not like seeking treatment for a leg fracture. Stigma remains, but it is decreasing – at least for depression and anxiety. Likewise, for a medical student considering specialty options, the stigma surrounding psychiatry is also decreasing: some of the best students now choose it, in increasing numbers. Nevertheless, in most areas of the world, the mismatch between need and supply of psychiatric expertise is profound [1]. The majority of mental health treatment is delivered by primary care providers (PCPs) [2].

In recognition of this mismatch between supply and demand, and the central role of primary care clinics in front-line psychiatric care, a new approach to the diagnosis and treatment of mental illnesses has emerged in the United States: the Collaborative Care Model (CCM). In this model, consulting psychiatrists do not interview patients directly (with occasional exceptions), but instead rely on data gathered by an in-clinic liaison. They communicate regularly with the liaison and PCPs (often via electronic health record, or telemedically). They follow cases using a registry managed by the liaison, to follow patients until they have responded (“treat to target”) [3]. Multiple randomized trials have found the CCM superior to care as usual for depression and anxiety, as well as a Cochrane review [4].

Accordingly, the CCM is being promoted as a means of addressing the shortage of psychiatrists. The American Psychiatric Association received a multi-million dollar grant from the U.S. Centers for Medicare and Medicaid to provide training in this approach. Entire U.S. states have adopted it (Washington, Minnesota) [3]. Focus of the CCM thus far has been almost entirely on depression and anxiety disorders. However, our experience with the CCM process, and our preliminary data shown herein, suggest that referred patients frequently have problems that are much more than simple depression or anxiety. Thus our interconnected hypotheses, as follows.
Hypotheses

1. In an efficient primary care system, the majority of mental illnesses can be handled by providers who are less expensive and more plentiful than psychiatrists.

2. A majority of the remaining cases will be bipolar disorder variations. Differentiating these from PTSD, or establishing that both are present, will be challenging and often require a psychiatrist’s input.

3. Psychiatric consultants can teach their primary care colleagues that bipolar diagnoses are estimations based on probabilities, rigorously assessed; they fall on a spectrum from unipolar to bipolar.

4. All providers must recognize that when bipolarity is missed, antidepressants often follow. These can induce bipolar mixed states, with attendant anxiety leading to benzodiazepine prescriptions; and potentially dangerous impulsivity and suicidality (often mistaken as a personality disorder).

5. Psychiatrists can help develop systems of care that identify bipolarity in primary care patients and differentiate it from (or establish comorbidity with) PTSD. Psychiatrists can facilitate appropriate treatment as well, including bipolar-specific psychotherapies as well as use of mood stabilizers.

Hypothesis 1: The “sieve effect of less expensive/more available providers

Fig. 1 describes a system of management for adults with mental illnesses presenting in primary care. A well-trained psychiatrist can handle nearly every one of the problems shown, but given the current difficulties accessing psychiatric services, and the expense of a psychiatrist relative to other well-trained providers, primary care clinics should develop teams of mental health providers who cost less and are more easily recruited. Some may be in-clinic, others available by referral. The latter requires a system of care coordination to make sure patients get to care (“closed loop” referral), because otherwise roughly half of these referrals will fail [5], especially in a Medicaid-rich population [6]. As depicted in Fig. 1, the net effect is a “sieve” which selects a subgroup of patients who need the input of a psychiatrist. We hypothesize that the majority of these patients have variations of bipolar disorder.

(Not shown are patients with complex and persistent mental illnesses, e.g. schizophrenia and severe bipolar disorder, who need a dedicated program with wrap-around services such as crisis management, housing, and employment assistance. If they have not bypassed primary care to go directly to such care, they should be referred. Many such programs now offer primary care services – so-called “reverse integration” [7]).

Proceeding through Fig. 1, by condition: first, most primary care clinics have a direct channel for referral to substance use treatment programs. Ideally such services would be available in-house, as in some of the Medical Homes in our system. Next in Fig. 1: Uncomplicated anxiety disorders, such as panic disorder, generalized anxiety disorder, even obsessive-compulsive disorder, are best managed, at least initially, with psychotherapy. Although each of these conditions has a specific evidence-based psychotherapy, a generic therapy for anxiety and depression, the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders [8], has recently shown sustained significant benefits in anxiety disorders (Hedges g = 0.92 at 18 months posttreatment) [9]. This would seem a logical place to start for most patients with anxiety in primary care. A group model has been investigated [10].

Continuing through Fig. 1: uncomplicated adult attention deficit disorders (ADD) have long been managed by primary care providers (PCPs), including the prescription of stimulants. Some additional psychoeducation for PCPs, which they can then pass along to patients and families, can be provided through a few consultations. A therapist can be recruited to provide the non-medication component of comprehensive ADD care, targeting academic and organizational skills per current research [11].

Situational depression is generally better handled by addressing the situation, if possible, than by prescribing an antidepressant medication. Some clinics have social workers who can brainstorm solutions to acute stressful problems. In their absence, closed loop referral to community providers can substitute; LCSWs are fortunately among the more plentiful of mental health providers.

Uncomplicated depression means: not co-morbid with an anxiety disorder; not pregnant; not suicidal; not exhibiting symptoms suggestive of a personality disorder; and not already shown to be treatment resistant by virtue of multiple failed trials of psychotherapy and antidepressants. In the original CCM model, these patients received simple psychotherapies — Behavioral Activation Therapy (BAT) and Problem-Solving Therapy (PST) — delivered following detailed manuals that prescribe weekly assignments with standardized worksheets. These treatments were offered by “Behavioral Health Consultants” (BHC), an in-clinic mental health liaison. Sometimes the BHC was a psychologist or social worker,
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