Treat the Whole Patient: Bring in the Psychiatrist

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Psychiatry and other behavioral specialties need to be made far more available to the primary care patient. This would bring the appropriate expertise to help treat the *inseparable* medical and behavioral problems, and would lower the stigmatization of behavioral treatment through its medicalization.

Consider the following: It is estimated that up to half of the population have symptoms consistent with one of the recognized psychiatric diagnoses described in DSM-5. Of those patients in whom psychiatric illness has been diagnosed, fewer than half have their symptoms treated by a physician. Of the half who receive psychiatric treatment, approximately 70% are treated by primary care physicians (PCPs) and only 30% ever see a behavioral therapist *or* a psychiatrist (1, 2). Consider also that PCPs often see patients whose behavioral problems "masquerade" as physical symptoms, which can cause—or significantly aggravate—chronic medical conditions that are currently the bane of our failing health care system: diabetes, hypertension, cardiovascular problems, obesity, smoking, and asthma. Failing to recognize behavioral symptoms not only perpetuates these problems, but it also leads to far worse outcomes for purely "medical" symptoms.

PCPs, however, are generalists. They are not expected to go into great depth in regard to their patients' behavioral symptoms, nor do they have the time (7 minutes per patient?). Having seen many patients who have experienced either partial or full treatment failures with their PCPs, I can relate the following highly common scenarios that routinely present to me.

•The PCP treats depression, but the dose of the antidepressant prescribed is far too low.

It is as if many PCPs feel comfortable only with prescribing what for most patients are subtherapeutic doses of antidepressant medications. As a result, the symptoms often do not improve at all, but if they improve somewhat, the patient is maintained on an inadequate dose and symptoms persist over long stretches of time. This is not, by any means, a "partial success." Persistent depressive symptoms lead to full relapses of depression and greatly increase the risk for suicidal behaviors. In addition, the longer depressive symptoms are allowed to fester, the deeper the "rut" they create in the brain. The longer the depression persists, the more likely it is that the patient will have another depressive episode sooner than the last, and the more difficult this episode will be to treat.

•The PCP has accurately diagnosed depression but has failed to detect that the depressive episode is but one feature of a broader bipolar disorder with both manic and depressive episodes.

He or she has prescribed an antidepressant for the patient, again for a considerable length of time, but the patient never improves. Indeed, a significant number of such patients suffer a *worsening* of their manic or hypomanic symptoms, such as irritability, aggressive behaviors, hyperactivity, and excessive spending. Not only do bipolar depressed patients often fail to respond to antidepressants alone, but the antidepressant actually *worsens* the

hypomanic symptoms and can generate a full-blown manic episode.

The PCP is not at fault for improper diagnosis in this situation. Often, hypomanic (less than fully manic) symptoms are subtle and quite difficult to detect; many psychiatrists miss them as well. Also, patients will more likely volunteer their depressive symptoms than their hypomanic symptoms, which they often prefer because of either the elation or the hyperactivity they experience as part of the episode. They do not define these experiences as "symptoms," and therefore they do not report them. Moreover, it is nearly impossible to elicit these symptoms in the brief amount of time a PCP is able to spend with his patient.

The result? As with depression, failure to diagnose bipolar disorder in a timely manner and to treat it early is not a neutral act. This too leads to deeper, more-treatment-refractory manic and/or depressive episodes and potential psychiatric hospitalization. Alas, statistics indicate that the average time between the onset of bipolar symptoms and the diagnosis is 8 years (3, 4). This is far too long for optimal treatment outcomes.

•The PCP has either underprescribed or overprescribed benzodiazepines for the patient's anxiety.

Underprescribing benzodiazepines is common because many PCPs fear they will induce an addiction in their patients, while over-prescribing or yielding to a patient's inappropriate demands for more abusable drugs and higher doses often leads to that very result.

•Whatever the diagnosis, PCPs and other physicians seldom detect dangerous behaviors, such as suicidal ideation or homicidal intent.

Identifying severe behavioral problems is not the strong suit of primary care, and nonpsychiatric physicians generally feel uncomfortable dealing with these extreme symptoms. Moreover, were the PCP to detect such behaviors, he likely would not know what resources to turn to nor would he have the time to follow through appropriately. As a result, the physician often chooses not to ferret out these behaviors lest they render him helpless to intervene. This leaves the patient, the physician, and the community in a serious and potentially dangerous situation, because the patient with extreme symptoms should be immediately transferred to a far more intensively monitored level of behavioral treatment.

None of this is meant to disparage PCPs. To the contrary: theirs is a demanding role that is under-recognized, underfunded, and significantly overtaxed for time. I have great respect for their work and their burdens. Still, many patients are not receiving optimal care when they fail to see a behavioral or psychiatric specialist. Unfortunately, there currently exists a dearth of psychiatrists to handle the vast demand for behavioral care. More important, the appropriate systems to effectively integrate behavioral health and primary care are only in their infancy at this time, and little or no attention is being paid to the cost-effective funding of such programs.

PCPs who wish to make a referral all too often cannot find a psychiatrist to evaluate the

patient soon enough. A wait of many months before a psychiatric appointment is available is not uncommon, and many psychiatric practices no longer accept new patients. To this may be added the many other barriers to appropriate behavioral care, such as transportation problems, inadequate insurance, and patient nonadherence to treatment and the stigma that is still attached to treatment.

Possible solutions

The solution may lie in the creation of new systems of medical-behavioral integration alluded to earlier. These systems are placing the psychiatrist, nurse, social worker, and/or case manager in the same clinic with their primary care peers. Patients are routinely screened for behavioral symptoms using standard paper and pencil screening tools. Mildly symptomatic patients are treated by the PCP, and those with more severe symptoms are treated by the behavioral health team, through some combination of psychiatrist, psychotherapist, nurse, nurse practitioner, social worker, and care manager. Patients are followed up telephonically to foster adherence to both their behavioral and their medical treatments. The psychiatrist is always available, in "real time," to consult with and to support the PCP on difficult cases and also serves as a formal educator to help his team and medical peers identify, correctly diagnose, and appropriately treat behavioral health problems.

In this way, psychiatric resources will be best leveraged for maximal impact on patients with highly common co-occurring medical and psychiatric problems. For this system to make the psychiatrist accessible to many more patients, it will require new funding mechanisms to cover the costs of services such as consultation between doctors and follow-up outreach to patients. However, these costs will be well offset by improved patient care in both the primary and behavioral care settings, as well as by reduced *medical* costs for emergency room visits, medical hospitalizations, and unnecessary laboratory testing.

The time has come to treat the *whole* patient. The time has come to make psychiatry part and parcel of primary care.

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