AMA
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PSYCHOPHARMACOLOGY

HOW-TO GUIDE

This how-to guide offers actionable, evidence-based best practices on psychopharmacology, when deemed medically necessary, enabling primary care physicians and other members of the care team to overcome key barriers to operationalizing integrated behavioral health (BH) care in their practice. This resource is reflective of the generous time and direction provided by numerous psychopharmacology subject matter experts with firsthand experience effectively integrating BH care within practices.

TERMINOLOGY:

- When "primary care physician (PCP)" is utilized in this document, it is inclusive of physicians across specialties—including family medicine, internal medicine, pediatrics, and obstetrics and gynecology. While not trained in primary care, non-primary care specialties, such as cardiology, gastroenterology, neurology, and oncology, can also benefit from integrating behavioral health into their practices to support their patients.
- While "patient" will be used throughout, note that this also encompasses the families and caregivers, who play an important role in integrated care.

CHILD AND ADOLESCENT

A Developmental Approach to Child and Adolescent Mental Health Care

While this how-to guide is primarily oriented to practices servicing adult patients, PCPs servicing younger patients (i.e. children and adolescents) may also prescribe medication following age-appropriate guidelines. PCPs should ensure, where appropriate, that patients are receiving the multimodal interventions (e.g., classroom accommodations, tutoring, evidence-based therapies) needed for relevant diagnoses. Co-management with child and adolescent psychiatry can be considered, particularly when the patient presents with more complex needs.

PCPs who serve children and adolescents have a unique opportunity to promote healthy mental and emotional development and safe, stable, nurturing relationships in families. Mental health (MH) concerns manifest differently in children than in adults; as such, pediatric approaches to behavioral health integration (BHI) can differ compared to adult practices. To that end, we have included guidance specific to child and adolescent MH care where appropriate. This type of information will be noted with the icon above.

PCPs may consult with their state's Child Psychiatry Access Program (CPAP), if one is available, for questions on prescribing. Additional training for free and at cost can be found through the American Academy of Pediatrics (AAP), The REACH Institute, Project TEACH, and UMass Chan Medical School.

Introduction

Individuals diagnosed with BH conditions can lead fulfilling and productive lives when provided appropriate treatment. There are many different options for treating patients with BH issues, with no one solution working for everyone. Treatments can include non-pharmacological interventions (such as the provision of social services, wellness programs, psychotherapy, etc.), psychotropic medications, or both. Despite the growing BH needs of patients, PCPs often feel ill-equipped to provide BH care treatment, particularly the prescription of psychotropic medications. To help address this challenge, this *Psychopharmacology How-To Guide* offers guidance to primary care practices regarding when and how to treat patients with psychotropic medications. Additional information on how to integrate psychopharmacology into your practice can be found in the BHI Collaborative's "Integrating Psychopharmacology Into Primary Care: When and How" webinar.

Align the Team

When treating patients with psychotropic medications, it is important that all members of the team have a common understanding of each person's roles and responsibilities.

Establishing and memorializing (documenting so others may see) this shared understanding should be a top priority during the BH Orientation.

Clear communication of roles and responsibilities should eliminate confusion about who is responsible for treatment decisions. Here's an example of what the team roles and responsibilities may look like:

Primary Care Physicians:

- Review the patient's medical history, substance history, family history, and social history
- Deliver brief intervention using motivational interviewing (MI) techniques for patients who screen positive for needing MH services
- Identify patients in need of further evaluation by BH clinician
- Meet weekly with BH clinician to review caseload and facilitate any further recommendations made by psychiatric consultant
- Provide patient education (symptoms, treatment plans, medications, side effects, etc.) to support patients in making informed treatment decisions
- Initiate and titrate psychotropic medications, order labs, and conduct further assessments as needed
- Manage case through notes/follow-up calls
- Perform ongoing assessments at each visit

BH Clinicians:

- Conduct further evaluation on patients who screen positive by PCP for uncontrolled illness or symptoms
- Diagnose and develop treatment plans in consultation with the PCP
- Meet weekly with psychiatric consultant to review the caseload and make any additional treatment modifications
- Meet weekly with PCP to communicate treatment modifications from psychiatric consultant and review caseload
- Conduct psychotherapy (if deemed appropriate)
- Follow up with patient to assess adherence and response to treatment
- Utilize measurement-based care tools for discharge planning criteria
- Manage case through notes/follow-up calls

Psychiatric Consultants (MD/DO):

- Meet weekly with BH clinician to review the caseload and make recommendations for treatment modifications
- Provide consultative support directly to PCP in managing complex cases, when appropriate
- Maintain ongoing education and contact with BH clinician and PCP regarding patient care, addressing ongoing gaps in knowledge
- In rarer cases, can prescribe psychotropic medication for short duration, if appropriate, prior to transitioning back to PCP for prescribing

Guiding Principles

The following are guiding principles when considering whether psychopharmacology is indicated as treatment for a patient with a BH condition(s):

Assess the medical aspects of a BH issue: Investigate potential underlying metabolic issues and medical causes (e.g., hormones, nutritional deficiencies, viruses, cognitive changes, etc.) via lab workup. Use open-ended inquiry to help patients identify triggers of their current symptoms or emotional discomfort.

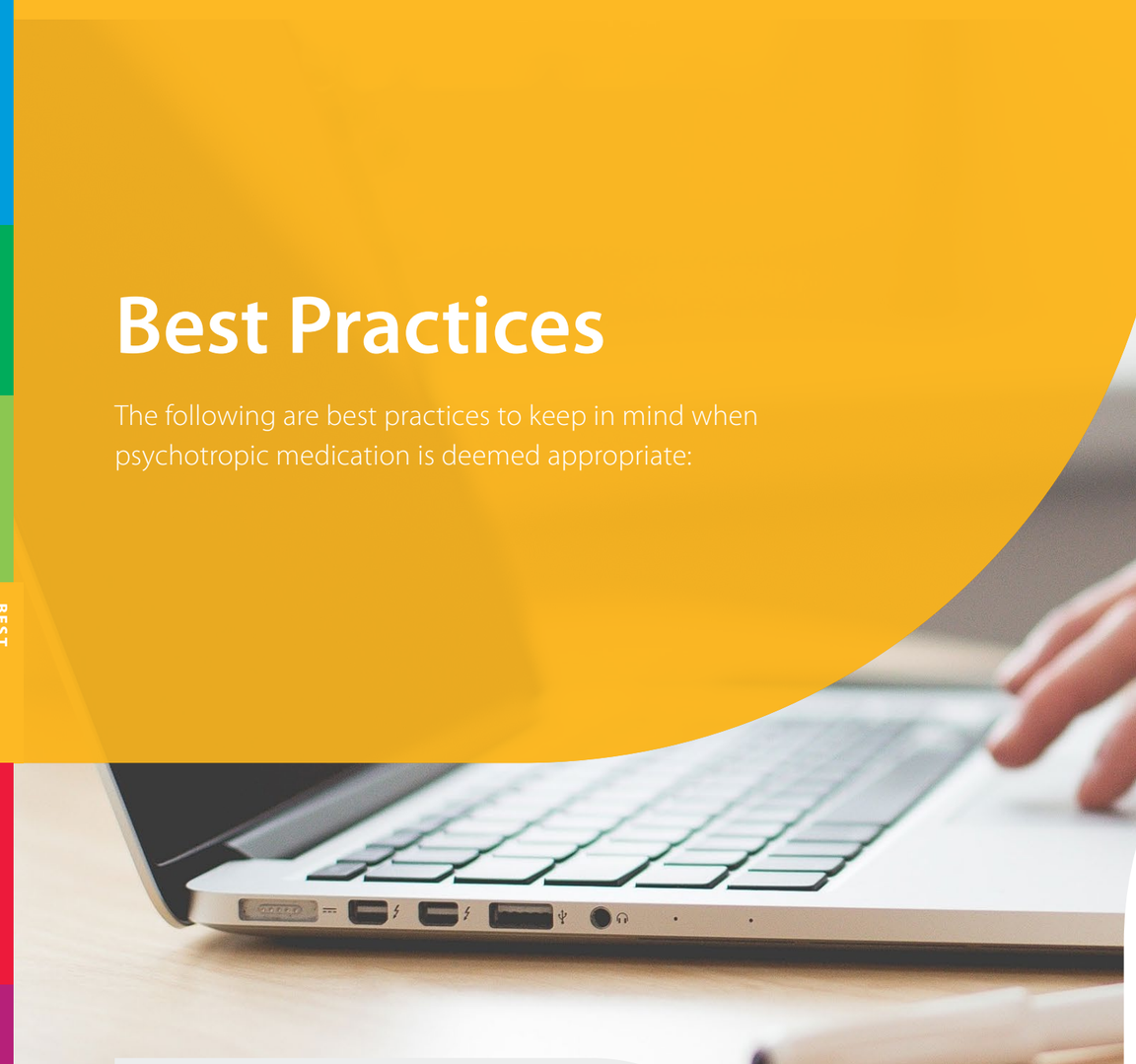
Always weigh the risk versus the benefit: Although psychotropic medications may be indicated to treat many BH conditions, they should only be prescribed after considering potential side effects, risk factors for adverse outcomes, and the risks, if any, of prolonged usage. If the patient is taking other medications for comorbidities, consider potential medication interactions and potential contraindications, as the risk profile may change, requiring additional monitoring. It is also important to consider alternatives to psychotropic medication and the risk of *not* prescribing the psychotropic medication, as well as the potential impact on the patient's outcomes.

Practice prescriptive parsimony: Attempt to use as few medications as possible to treat the BH condition(s) and comorbidities to help with adherence and tolerability.

TIP: **Treatment escalation may be necessary** if a patient is non-adherent, experiencing exacerbation of a current condition(s), diagnosed with a more severe illness, or is a danger to themselves or others. It is recommended that practices create and maintain a referral list with information about clinicians and facilities that can provide higher levels of treatment as needed. The National Alliance on Mental Illness (NAMI) provides resources that help inform what support services are available within designated regions.

Best Practices

The following are best practices to keep in mind when psychotropic medication is deemed appropriate:



TIP:

Confirm and document the rationale for usage and the patient's consent when prescribing medications off-label. Ensure the patient is provided adequate education about the psychotropic medication and why it is being used off-label.

Document the decision-making process: Capture the rationale for prescribing psychotropic medication, potential side effects, and patient consent (ideally within the electronic health record (EHR) notes when available); if the patient declines recommended therapy, their decision should be similarly documented.

Titrate medications appropriately: Proper titration allows for an adequate trial of the psychotropic medication. If not properly titrated (e.g., by starting at or continuing too low a dose or not continuing a dose long enough), efficacy cannot be determined, nor whether different treatment is indicated. Follow FDA dosing recommendations by starting at the appropriate dose and titrating by the recommended amount and frequency.

Follow the clinical trial follow-up schedule: The schedule of follow-up tests used in clinical trials should be mirrored in practice to monitor patient response and decide if dose modification is indicated. Include closer follow-up for high-risk populations such as older adults or patients with additional medical comorbidities. Keep in mind how pharmacodynamics and pharmacokinetics change with age, liver, and kidney function and that certain populations may be at increased risk with certain side effect profiles such as anticholinergic medications.

Be proactive while monitoring: Track the patient for response, remission, recovery, and relapse.

Be mindful when prescribing controlled substances: Psychotropic medications that are controlled substances (such as benzodiazepines for Panic Disorder, stimulants for Attention-Deficit/Hyperactivity Disorder (ADHD), and other potentially habit-forming or diverted medications) require extra precaution. A thorough substance use history should be taken before prescribing.

Implementing Treatment

The range of BH conditions treated within a primary care practice will depend largely on the comfort level of the PCPs. This is often based on experience in utilizing psychotropic medications, capacity, and the degree of BHI and associated support from specialized clinicians.

When deciding upon psychiatric medication, collaboration with the BH clinician and psychiatric consultant is key, as well as referencing psychopharmacology resources, such as The Waco Guide to Psychopharmacology in Primary Care. The following table outlines common BH disorders you may see in primary care, along with the screeners and medication types used to diagnose and treat.

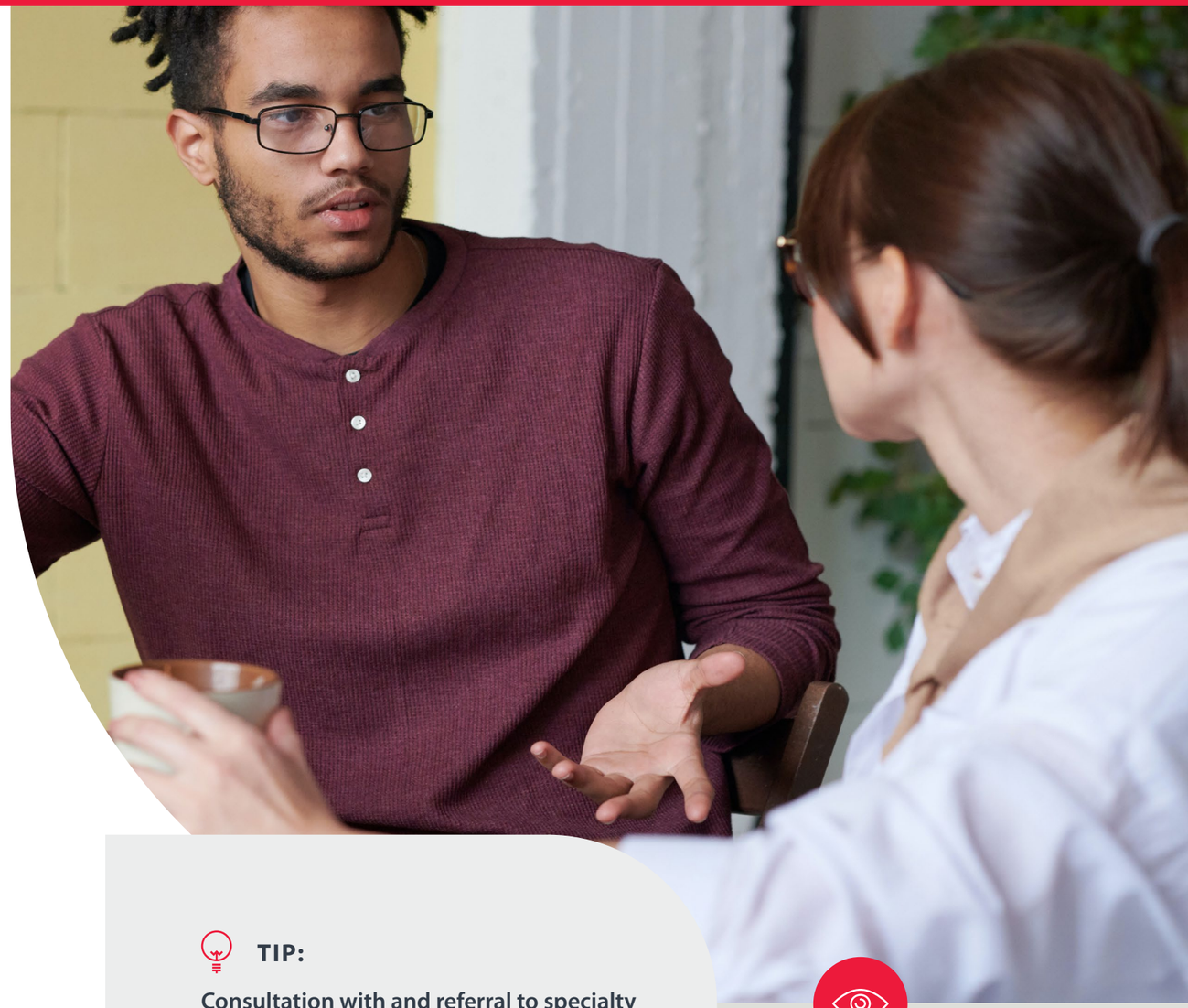
	DEPRESSIVE DISORDERS	ANXIETY DISORDERS & OBSESSIVE-COMPULSIVE AND RELATED DISORDERS
CONDITIONS ADDRESSED	• Major Depressive Disorder (MDD) • Premenstrual Dysphoric Disorder (PMDD) • Persistent Depressive Disorder (PDD) • Depressive Disorder due to another medical condition (e.g., stroke, Parkinson's disease, TBI, hypothyroidism, pancreatic cancer) • Prolonged Grief Disorder (PGD)	• Generalized Anxiety Disorder (GAD) • Specific phobias (e.g., airplane travel) • Social Anxiety Disorder (e.g., public speaking, meeting unfamiliar people) • Panic Disorder and panic attacks • Agoraphobia • Anxiety Disorder due to another medical condition (e.g., CHF, Afib, COPD, Asthma) • Obsessive-Compulsive Disorder (OCD)
SCREENERS USED TO DIAGNOSE	• Patient Health Questionnaire-9 (PHQ-9) • Montgomery-Asberg Depression Rating Scale (MADRS) • Mood Disorder Questionnaire (MDQ) – *used to rule out bipolar disorder* • Columbia Suicide Severity Rating Scale (C-SSRS Screener)	• General Anxiety Disorder-7 (GAD-7) • Mood Disorder Questionnaire (MDQ) – *used to rule out bipolar disorder* • Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)
DRUG CLASS/ MEDICATION TYPES	• Selective serotonin reuptake inhibitors (SSRIs) • Serotonin and norepinephrine reuptake inhibitors (SNRIs) • Norepinephrine and dopamine reuptake inhibitors (NDRIs) • Tricyclic Antidepressants (TCAs) • Bupropion – *more often used as an adjunct for patients who have sexual side effects from medication or for patients who additionally have tobacco use disorder* • Antipsychotic medications – *used as adjunctive treatment and for patients with psychotic features*	• Selective serotonin reuptake inhibitors (SSRIs) • Serotonin and norepinephrine reuptake inhibitors (SNRIs) • Beta-blockers – *useful for Social Anxiety Disorder with fear of public speaking, tremor* • Benzodiazepines – *used for panic attacks or specific phobias such as airplane travel. Not first line for general anxiety, nervousness, or temperamental anxiety. Can cause dependency when used chronically* • Antipsychotic medications – *used as adjunctive treatment, can be helpful in OCD*

Chart continued on next page

	NEURODEVELOPMENTAL & SLEEP-WAKE DISORDERS	SCHIZOPHRENIA SPECTRUM & OTHER PSYCHOTIC DISORDERS*	BIPOLAR AND RELATED DISORDERS & DISORDERS INCLUDING IMPULSIVITY**
CONDITIONS ADDRESSED	• Attention-Deficit/Hyperactivity Disorder (ADHD) • Narcolepsy • Hypersomnolence Disorder	• Schizophrenia including Schizophrenia Spectrum illnesses • Schizoaffective Disorder • Substance/Medication-induced Psychotic Disorder • BPAD I including psychotic features • MDD with psychotic features	• Bipolar Affective Disorder I (BPAD I) • Bipolar Affective Disorder II (BPAD II) • Cyclothymic Disorder • Borderline Personality Disorder (BPD) • Disruptive, Impulse-Control, and Conduct Disorders
SCREENERS USED TO DIAGNOSE	• NICHQ Vanderbilt Assessment Scales • Adult Self-Report Scale (ASRS v1.1) for ADHD – *recommended for BH clinician to conduct sleep study including sleep latency test*	• Mood Disorder Questionnaire (MDQ) – *used to assess for BPAD* • Positive and Negative Syndrome Scale (PANSS) • Abnormal Involuntary Movement Scale (AIMS)	• Mood Disorder Questionnaire (MDQ) – *used to assess for BPAD; key to watch for irritability and early psychosis* • Positive and Negative Syndrome Scale (PANSS) *for patients with psychotic features* • Screen for substance use – *a manic or hypomanic episode must be during periods of sobriety*
DRUG CLASS/ MEDICATION TYPES	• Short-acting amphetamine stimulants • Short-acting methylphenidate stimulants • Intermediate-acting methylphenidate stimulants • Long-acting amphetamine stimulants • Long-acting methylphenidate stimulants • Long-acting non-stimulants including atomoxetine, guanfacine ER, clonidine ER	• Typical antipsychotics including long-acting injectables (LAIs) • Atypical antipsychotics including LAIs • Mood stabilizing medications for BPAD and Schizoaffective disorders • Antidepressant medications for MDD and Schizoaffective disorder, also often used in patients with Schizophrenia	• Divalproex Sodium (Depakote) – *comes in ER tablets, DR tablets, or capsule sprinkles. Can have severe effects on pregnancy and counseling should be provided to those appropriate* • Valproic Acid (Depakene) – *comes in liquid and capsule form. Can have severe effects on pregnancy and counseling should be provided to those appropriate* • Lamotrigine (Lamictal) • Lithium • Typical and Atypical Antipsychotic medications – *first line to help with mania given quick onset while mood stabilizers are titrated*

*Though not classified as "Schizophrenia Spectrum and Other Psychotic Disorders" in the DSM-V, depressive disorders and bipolar disorders with psychotic features have been included here for the overlap in screeners and medication types used to diagnose and treat.

**For the purposes of the guidance provided in this table, "Disorders Including Impulsivity" is meant to encompass borderline personality disorder and disruptive, impulse-control, and conduct disorders.



TIP:

Consultation with and referral to specialty care may be indicated when individual patient factors complicate diagnosis and treatment. As with all diseases and disorders, patients may present medical complexities beyond a PCP's expertise or comfort level. For example, certain adolescents, individuals who are pregnant, older adults, or those who have co-occurring psychiatric disorders may require specialty care.

WATCH OUT:

Avoid more than one month of medication refills as it may result in too few follow-up appointments, which are necessary to evaluate treatment effectiveness.

Partnering with Patients, Families, and Caregivers

Collaboration

Talking with patients about BH conditions and psychotropic medication requires sensitivity and particular care. If done abruptly or in an insensitive manner, patients may feel defensive or put off by the idea of BH treatment, including psychotropic medication.

When clinicians are comfortable having these conversations, patients will feel more at ease. Here are some ways to have these conversations so patients feel supported and the members of the integrated care team are similarly confident and grounded:[i]

Establish an environment of trust: Share appreciation for the patient being there, and describe your commitment to providing comprehensive, integrated care by discussing your policy of screening all patients for a variety of conditions; express gratitude and appreciation for responses shared and remind them that sharing information helps you work together to ensure the best care.

Engage in reflective listening: Validate the patient's feelings and emotions so they feel understood; maintain good eye contact.

Communicate on a "person-to-person" level: Build rapport and trust by using language the patient clearly understands; avoid clinical and pathological terminology as well as projecting judgment.

Suggest treatment options, not directives: Ensure that the patient is a part of the treatment decision-making process while providing recommendations based on facts of diagnosis and history, not solely on the patient's request.

Positively frame psychopharmacology: Some patients may feel shame in not being able to improve their symptoms without medications. Provide encouragement that adhering to the psychotropic medication that is predicted to best address their BH condition is the first step to a more fulfilling and productive life and that adjustments will be made based on their response to treatment. If deemed clinically appropriate and age appropriate, normalize medication as a tool, in addition to other tools such as psychotherapy, behavioral activation, personal strength and motivation, and other multimodal interventions.

TIP: **Reference the American Academy of Child and Adolescent Psychiatry (AACAP) Resource Center** for useful definitions, resources, and videos to help facilitate the conversation when discussing BH challenges with pediatric patients, families, and caregivers.

Setting Expectations

In addition to partnering with patients, it is crucial to set and manage expectations.

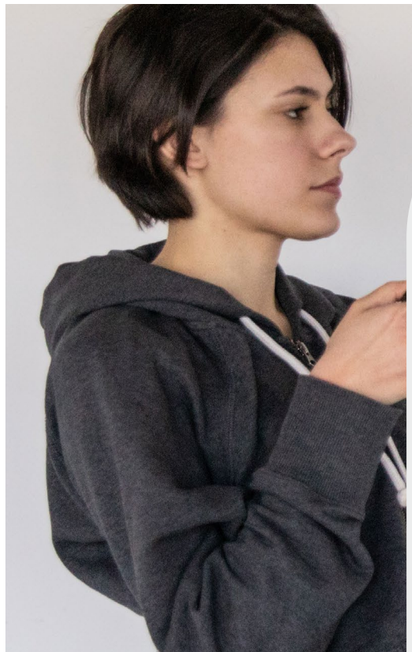
This helps the patient know what to watch for in terms of side effects and progress, remain confident in the approach, and adhere to treatment. Topics to discuss when setting expectations include:

Medication capacity: This is how well the medication can be expected to work. For example, if a patient struggles with ADHD, clearly describe what a full response may be.

Treatment plan: Share what will be tried first, the likelihood of it working, and what the next steps may be if the first treatment is not working. It can be helpful to share that not all psychotropic medications work to the same degree for everyone, and therefore, the plan may require some adjustments.

Side effects: This helps prepare the patient to recognize side effects and know what to do should they arise. Ensure that the length of time that side effects can be expected is discussed thoroughly with the patient.

Individual success metrics: These should be customized for and agreed upon with the individual patient to measure treatment success. For example, if treating a pediatric patient, completing a certain grade level may be a metric to strive for.



TIP:

For further information on destigmatizing BH care and the use of psychotropic medication, reference the BHI Collaborative's Physicians Leading the Charge: Dismantling Stigma Around Behavioral Health Conditions and Treatment webinar, considerations from the AAP, and the cultural competency guidance found in the BHI Collaborative's BHI Compendium.

Address Stigma

While the stigma around BH conditions is lessening, it can still keep patients from seeking and receiving appropriate care, including psychotropic medication when needed.

Negative consequences of stigma include delays in seeking help, discontinuation of treatment, suboptimal therapeutic relationships, patient safety concerns, and poorer care outcomes.[ii] While difficult to address head-on, there are strategies that can help reduce stigma, specifically stigma that may be present within the primary care team, which can have a compounding impact on patient and societal perception around behavioral health and acceptance of psychotropic medication. Such strategies include:

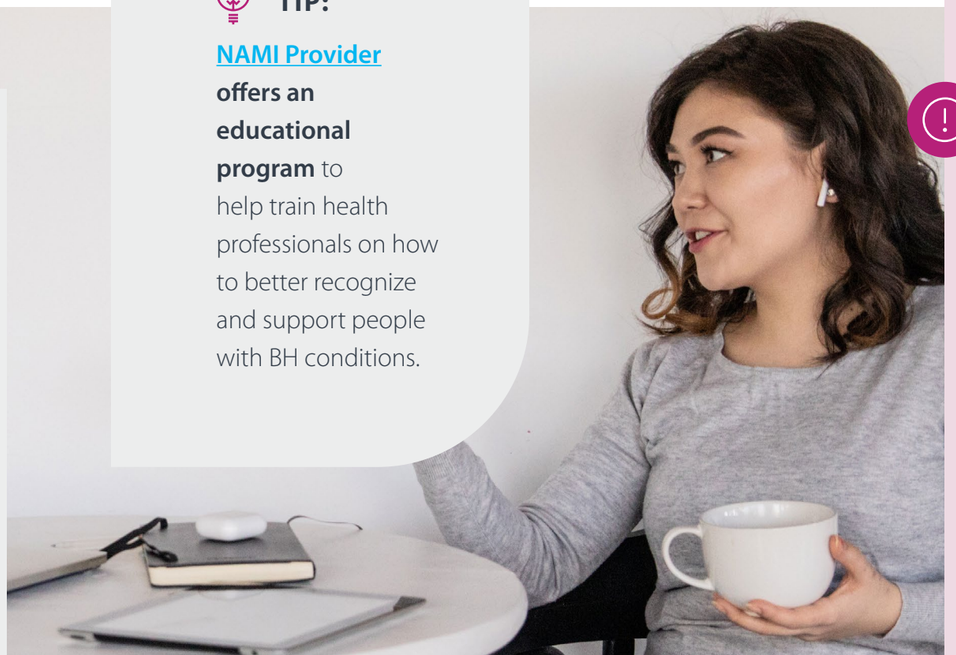
Uncovering unconscious bias: Address false beliefs that may exist within the care team, the community, or culture that impact perceptions around BH conditions.

Letting patients be the educators: Create space for the primary care team to listen to testimonies from people with BH conditions and connect with them on a more personal level.

Showing that recovery is possible: Empower the primary care team to be a part of the solution, highlighting how recovery can happen, particularly because of their role in it.

TIP:

NAMI Provider offers an educational program to help train health professionals on how to better recognize and support people with BH conditions.



CALLOUT:

For information regarding billing and coding that will help with BHI and Psychopharmacology, check out the BHI Collaborative's BHI Compendium for a list of resources and Substance Abuse and Mental Health Services Administration (SAMHSA) for a list of grants available by state to help you get started.

Practice Spotlight

In recent years, Waco Family Medicine (WFM) has successfully integrated BH care, and as team-based screening became more routine, detection rates of depression increased. While thankful to identify previously undiagnosed disorders, the practice also recognized that many of its PCPs lacked clinical support tools to navigate the challenges of a growing caseload of BH conditions.

With these needs in mind and support from the highest level of the organization, the WFM team sought to improve the quality of BH care in the primary care setting by providing clinicians with point-of-care decision support. In consultation with the Massachusetts General Hospital Psychiatry Academy faculty, the Waco team synthesized available evidence-based guidelines, high-impact literature, and expert opinion to develop psychopharmacology clinical decision support tools tailored for use by PCPs. The team prioritized the mental and behavioral disorders most commonly seen in the primary care setting, including depressive disorders, anxiety and trauma-related disorders, bipolar disorder, substance use disorders, and psychotic disorders. The resulting collection of tools is now referred to as The Waco Guide to Psychopharmacology in Primary Care.

After several iterations and refinements, The Waco Guide was distributed to community clinicians and is credited with rising clinician confidence and their propensity to screen in primary care clinics. The guide is now being adopted by practices across the country. It is also credited with increasing patient and clinician satisfaction. For example, one OBGYN reported that the clinical decision support tool allowed her to navigate a particularly challenging case involving an expectant patient with bipolar disorder. The physician and patient discussed the relevant risks and benefits of treatment and formulated a plan that was aligned with the patient's values. Use of The Waco Guide set them on a course of treatment that contributed to a healthy pregnancy outcome and a delighted mom, baby, and physician.

REFERENCES

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[ii] Knaak, S., Mantler, E., & Szeto, A. (2017, March). *Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions.* Healthcare management forum. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5347358/