Consultation-Liaison Psychiatry: The best of both worlds

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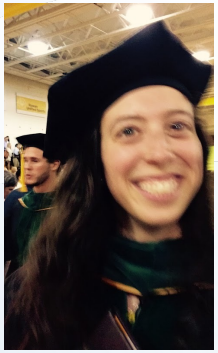
Thanks to Anique Forrester MD for inspiration with structure and deidentified cases.

MY JOURNEY TO MEDICINE

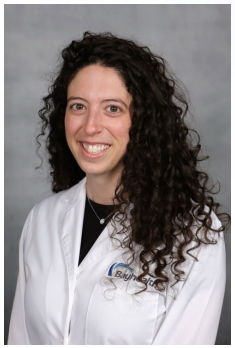
2006-2010
BA Neuroscience
Hamilton College



2012-2016
Medical School
Rowan SOM

2016-2020
Psychiatry Residency
Thomas Jefferson University Hosp

2020-2021
CL Fellowship
Brigham & Women's/HMS



2021-present
Attending
Bayhealth Medical Center

2010-2012
Lifeguarding, teaching, studying, interviewing

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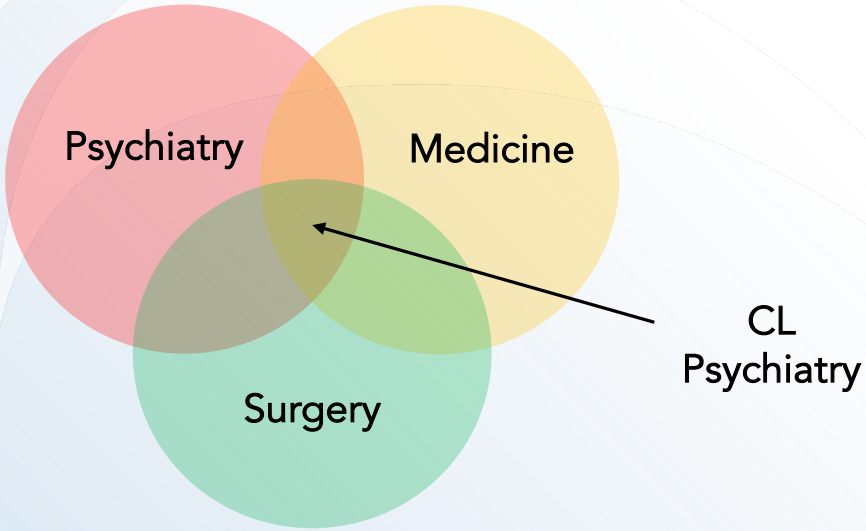
WHAT IS CONSULTATION-LIAISON PSYCHIATRY?

CLP is a subspecialty within psychiatry that involves the interface between psychiatry and other medical/surgical specialties.



Fellowship-trained CL docs have extra training in:

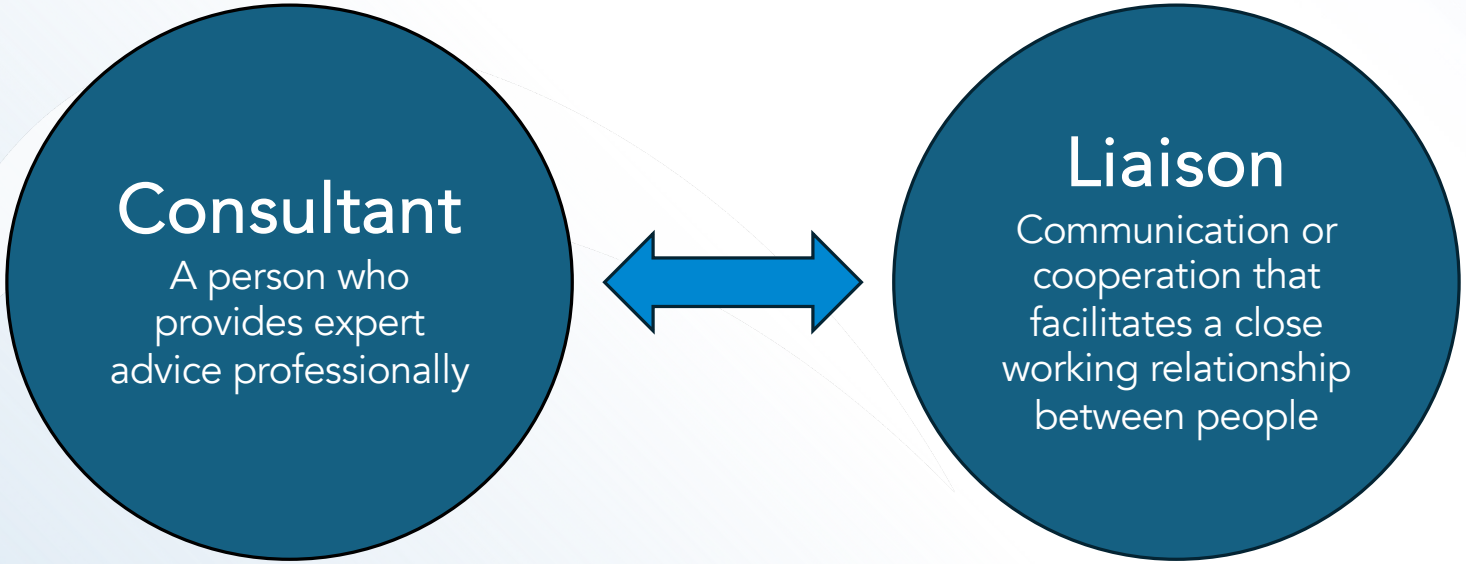
- Diagnosing/treating psychiatric illnesses in the medically ill
- Psychopharmacology
- Medical illnesses with psychiatric sequelae
- Managing countertransference
- Medicolegal issues

WHAT IS CONSULTATION-LIAISON PSYCHIATRY?

- Specialty first recognized in 2003 – "Psychosomatic Medicine"
- Name change in 2018 – "Consultation-Liaison Psychiatry"

- Training in CL begins in psychiatry residency where every resident must complete at least 2 months
- 1 year fellowship in CL psychiatry must be completed to pursue board certification

IN ORDER TO TRULY UNDERSTAND WHAT CL PSYCHIATRY IS, WE NEED TO DEFINE SOME FANCY WORDS…



"Talk, consult, talk"

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THE BEST CL PSYCHIATRISTS HAVE THESE INTERESTS:

- Caring for those with significant medical illness and knowing how these illnesses affect mental health
- Working with treating physicians to optimize the patient's care
- Educating colleagues, patients, families about mental illness, how to identify and treat those illnesses in the medically ill, and recognizing psychiatric manifestations of medical illness
- Thinking about the complex care needs for hospitalized patients and how to integrate those better within healthcare

CL PSYCHIATRISTS WORK IN A VARIETY OF SETTINGS

Hospital

Emergency Room

Outpatient Clinic

CL PSYCHIATRISTS WORK IN A VARIETY OF SETTINGS

Hospital

Emergency Room

Outpatient Clinic

- Performs (reactive) consultations for patients admitted to the various services in the hospital
- May attend rounds, listening to case presentations and suggest which patients might benefit from earlier (proactive) psychiatric intervention, or offering the team suggestions on how to collaborate more effectively with patients who are, ex: exhibiting behavioral problems that are complicating their medical care
- May be involved in medicolegal/ethical consultations such as evaluating decision making capacity or participating on an ethics committee

CL PSYCHIATRISTS WORK IN A VARIETY OF SETTINGS

Hospital

Emergency Room

Outpatient Clinic

- Performs psychiatric consultations in the emergency setting, usually risk assessments, helping to evaluate whether an acute behavioral change may be due to a medical (delirium, dementia) and/or psychiatric problem (depression, schizophrenia) and recommending appropriate treatment or level of care

CL PSYCHIATRISTS WORK IN A VARIETY OF SETTINGS

Hospital

Emergency Room

Outpatient Clinic

- May have an outpatient practice treating patients with complex medical conditions
- Often with an interdisciplinary approach to patient care
  - ex: access to a variety of services such as social work, nutrition, or case management
- May provide psychiatric consultations and oversight of a large medical setting, listen to case presentations, and offer suggestions to the patients' primary care clinicians on how to manage concerns and provide education to the program staff about psychiatric illnesses

TYPES OF PSYCHIATRY CONSULTS

Psychiatric presentations of medical conditions
[anxiety → hyper/hypothyroidism]

Medical presentations of psychiatric conditions
[chest pain → panic attack]

Medical complications of psychiatric conditions or treatment
[NMS, SS, EPS]

Psychiatric complications of medical conditions or treatments
[psychosis in PD]

Comorbid medical and psychiatric conditions
[epilepsy + primary psych]

Psychological reactions to medical conditions or treatments
[disfigurement, coping with illness]

SAMPLE CASE 1

Ms. Smith is a 32F with no significant past medical history

- Severe constipation and occasional rectal bleeding for ~2y
- Seen in the ER with severe abdominal pain, workup reveals rectal CA
- Currently undergoing biweekly chemo and has continued issues with treatment noncompliance

The oncology team consults psychiatry to evaluate her for depression as a possible cause for her noncompliance

KNOWLEDGE OF NON-PSYCHIATRIC CAUSES OF DEPRESSION MAY GUIDE YOUR WORKUP (Levenson, 2019; Birrer & Vemuri, 2004)

Medical Causes of Depression

Parkinson's Disease
CVA
CAD
Cancer
Diabetes
Thyroid disorders
B12 deficiency
Dementia
SLE
MS
Hyperparathyroidism
Celiac disease

TABLE 2

Medications That May Cause Depression

Cardiovascular drugs

Clonidine (Catapres)
Digitalis
Guanethidine (Ismelin)
Hydralazine (Apresoline)
Methyldopa (Aldomet)
Procainamide (Pronestyl)
Propranolol (Inderal)
Reserpine (Serpasil)
Thiazide diuretics

Chemotherapeutics

6-Azauridine
Asparaginase (Elspar)
Azathioprine (Imuran)
Bleomycin (Blenoxane)
Cisplatin (Platinol)
Cyclophosphamide (Cytoxan)
Doxorubicin (Adriamycin)
Mithramycin (Mithracin)
Vinblastine (Velban)
Vincristine

Antiparkinsonian drugs

Amantadine (Symmetrel)
Bromocriptine (Parlodel)
Levodopa (Larodopa)

Antipsychotic drugs

Fluphenazine (Prolixin)
Haloperidol (Haldol)

Sedatives and antianxiety drugs

Barbiturates
Benzodiazepines
Chloral hydrate
Ethanol

Anticonvulsants

Carbamazepine (Tegretol)
Ethosuximide (Zarontin)
Phenobarbital
Phenytoin (Dilantin)
Primidone (Mysoline)

Anti-inflammatory/anti-infective agents

Ampicillin
Cycloserine (Seromycin)
Dapsone
Ethambutol (Myambutol)
Griseofulvin (Grisactin)
Isoniazid (INH)
Metoclopramide (Reglan)
Metronidazole (Flagyl)
Nalidixic acid (NegGram)
Nitrofurantoin (Furadantin)
Nonsteroidal anti-inflammatory agents
Penicillin G procaine
Streptomycin
Sulfonamides
Tetracycline

Stimulants

Amphetamines (withdrawal)
Caffeine
Cocaine (withdrawal)
Methylphenidate (Ritalin)

Hormones

Adrenocorticotropin
Anabolic steroids
Glucocorticoids
Oral contraceptives

Other drugs

Choline
Cimetidine (Tagamet)
Disulfiram (Antabuse)
Lecithin
Methysergide (Sansert)
Phenylephrine (Neo-Synephrine)
Physostigmine (Antilirium)
Ranitidine (Zantac)

MAJOR DEPRESSIVE DISORDER IS MORE COMPLEX THAN "SIG E CAPS" BUT IT'S A GOOD START

SIG E CAPS + anhedonia

Sleep disturbance
Interests decreased
Guilt or worthlessness
Energy decreased
Concentration decreased
Appetite disturbance
Psychomotor changes
Suicidal thoughts (thoughts of death)

Clinical Criteria for MDD

- 5 of 9 symptoms, all day, x2 weeks
- Cause clinically significant distress or impairment
- Not attributable to substance use or another medical condition

LOOK FAMILIAR?

Sour puss face

Watching TV constantly (cartoons)

Lights off

Doesn't want to get up

Warm blankie

Pillow from home

Drink & snackie (junk food)

Messy room

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SAMPLE CASE 1

Ms. Smith: "I don't know why they are so upset. It's my body and the chemotherapy makes me sick. I feel better when I miss treatments here and there, but I do want to get better."

- No significant past psychiatric history but has an extensive history of sexual trauma
- Denies prior and current psychiatric symptoms
- Has very limited support system and is currently unemployed

SAMPLE CASE 2

Mrs. Jones is a 62F with a history of Lupus

- No prior psychiatric history
- Paranoid, delusional (reports there is cancer all over her body), agitated, hyper-religious, and hypersexual
- Concern for lupus cerebritis, but she is too altered for testing

The ER and Rheumatology consult psychiatry for assistance with behavioral management.

PRINCIPLES OF TREATING AGITATION

"The patient is agitated."

PRINCIPLES OF TREATING AGITATION

- "Turns down the volume": allows you to examine the patient and gather more data about what may be causing the agitation
- We have many options available to us
  - Mild, moderate, severe agitation
- One option is pharmacologic agents to treat agitation
  - Rapidly calm without oversedation
  - Non-invasive > invasive whenever possible
- Keep the cause of agitation in mind as you choose from your options
- Balance patient and staff safety

SAMPLE CASE 2

Medical workup includes

- LP with sedation, ANA
- CT and MRI with contrast: small vessel disease, no acute findings
- Steroids (1g methylprednisolone) with some improvement per spouse

Recommended to start quetiapine for psychotic symptoms. Eventually discharged home with a plan to taper quetiapine and steroids.

SAMPLE CASE 3

Mr. Johnson is a 26M who identifies as MSM

- Diagnosed with HIV in 2011, has not been on HAART in 9m (3rd clinic)
- Presents to clinic to restart
- History of sexual and physical abuse in childhood
- Smoking cannabis daily, occasional cocaine, unstable housing
- Unemployed, no family supports, receives food stamps

Referred to psychiatry for evaluation for depression and substance use.

SOCIAL DETERMINANTS OF MENTAL HEALTH

The conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. (Healthy People 2030)

- Adverse childhood experiences
- Racism, social exclusion
- Exposure to violence
- Criminal justice involvement

Societal problems

Socioeconomic status and opportunities for accruing wealth

- Low educational attainment
- Unemployment or job insecurity
- Poverty and income inequity
- Neighborhood poverty

- Adverse built environment
- Neighborhood disorder
- Pollution
- Global climate change impact

Immediate and global physical environment

Basic needs: housing, food, transportation, healthcare

- Housing instability
- Food insecurity
- Poor access to transportation
- Poor access to healthcare

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Adapted from: NY State Office of Mental Health

SUBSTANCE USE & MENTAL HEALTH

Cocaine

- How it works:
  - Blocks DA reuptake transporters
  - Rapid, intense increase in DA concentration followed by sharp drop
- Intoxication: euphoria
  - Also: agitation, paranoia, anxiety
- "Crash"
  - Depression, anxiety, cravings

Cannabis

- Intoxication: relaxation, euphoria
  - Also: depression, anxiety, psychosis
  - Unpredictable course depending on route of administration, dose, strain
- Caution
  - Interactions with many commonly used medications
  - Dispensary employees are sales people, not prescribers
  - No standards with chemical makeup of product

SAMPLE CASE 3

- Main concerns: applying for disability and lack of stable housing
- Does not feel cannabis is a problem and declines substance abuse treatment
- Feels occasionally depressed and isolated but denies SI
- Improves regarding medical visits but still misses psychiatry appointments on a regular basis
- Started on an antidepressant but shows limited improvement
- Intermittently +cocaine but usually always +THC

Eventually accepts substance abuse treatment, adherence to HAART improves, but still misses appointments occasionally

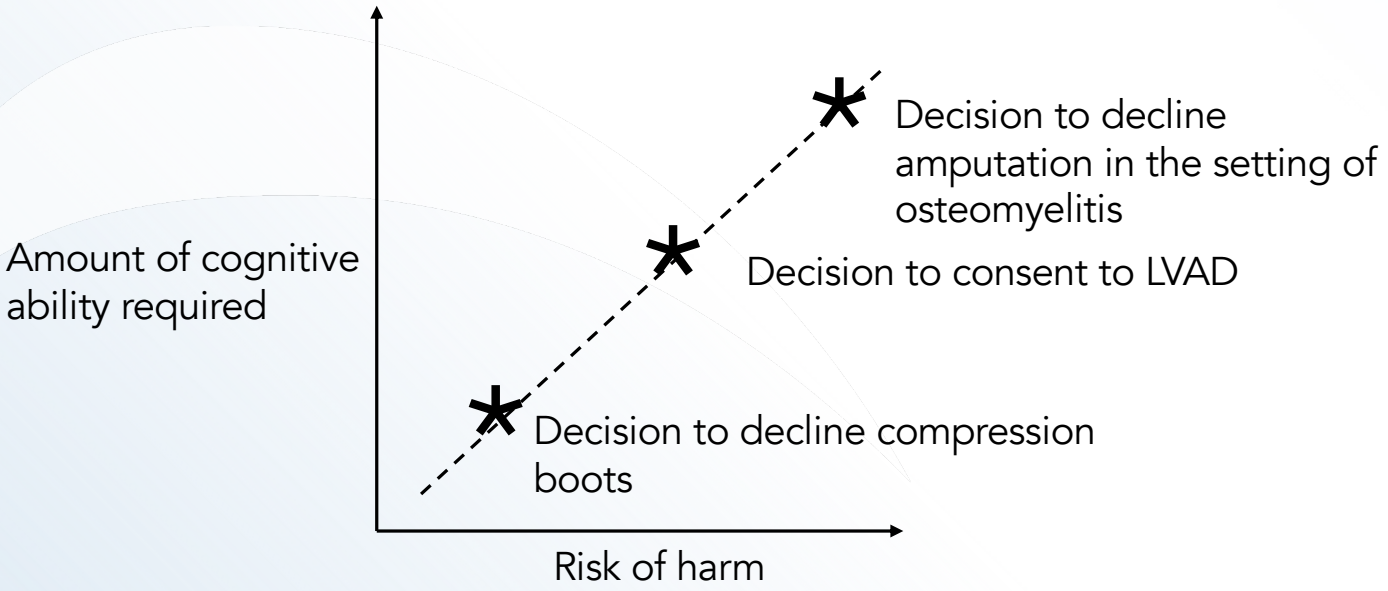
SAMPLE CASE 4

Miss Harris is a 75F with DM2, PVD admitted with gangrenous ulcer on her R foot

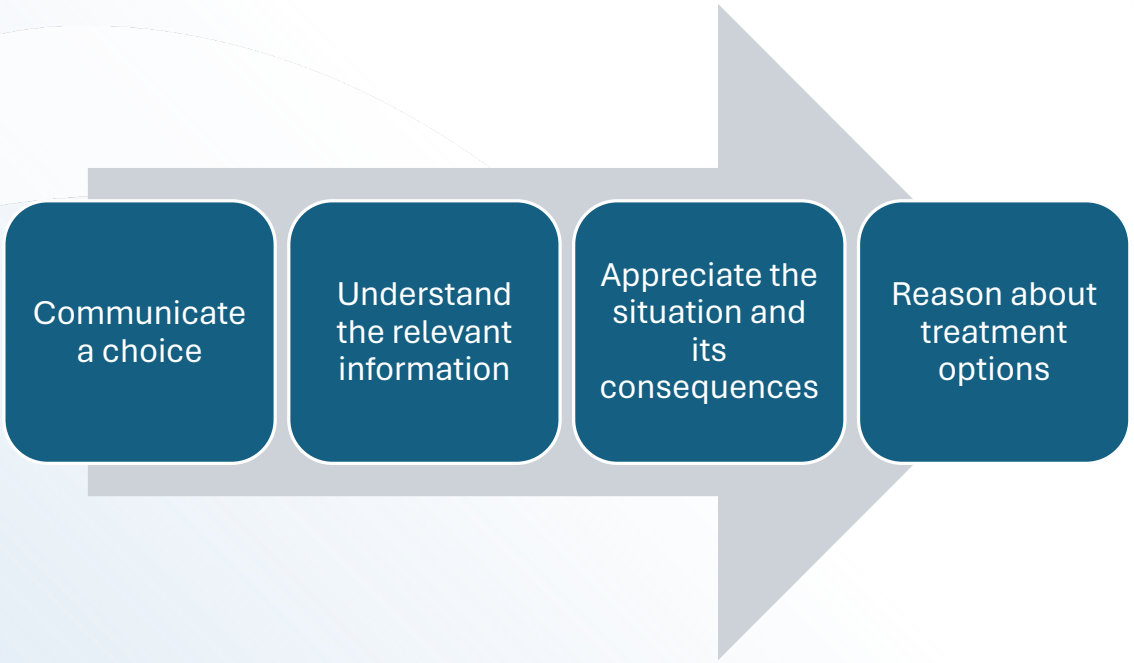
- Surgery recommends a BKA
- Patient declines, stating she has lived long enough and wants to die with her body intact
- Her daughter reports she is increasingly confused over the last year and now is concerned for depression

Psychiatry is consulted to assess the patient's capacity to refuse BKA.

CAPACITY IS A SLIDING SCALE



EVALUATING A PATIENT'S DECISION-MAKING CAPACITY (Appelbaum, 2007)



SAMPLE CASE 4

1. Communicate a choice
2. Understand relevant information
3. Appreciate the situation and its consequences
4. Reason about treatment options

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1. **Communicate a choice**
2. Understand relevant information
3. Appreciate the situation and its consequences
4. Reason about treatment options

"I don't want them to cut off my foot. I don't know how many times I have to tell you - I'm not having it done. You can't make me do it."

SAMPLE CASE 4

1. Communicate a choice
2. **Understand relevant information**
3. Appreciate the situation and its consequences
4. Reason about treatment options

"The doctor told me that I have an infection on my foot and that they need to cut off my foot to cure it."

SAMPLE CASE 4

1. Communicate a choice
2. Understand relevant information
3. **Appreciate the situation and its consequences**
4. Reason about treatment options

"I know I've got an infection, it's been there for a while, I know that. It's really painful. The treatment may cure it, but I don't want to live with my foot cut off. So just give me pain medications and I'll be OK."

SAMPLE CASE 4

1. Communicate a choice
2. Understand relevant information
3. Appreciate the situation and its consequences
4. **Reason about treatment options**

"I'm really worried about the surgery. What would happen if something went wrong? I'd die anyway. Then what will I do about getting around? They're not gonna give a new foot to an old lady like me. How will I play with my grandkids? And what about the pain after? It will be unbearable. I would just be better off if I died – with my foot attached."

SAMPLE CASE 4

Anxiety is a barrier to accepting treatment

- Asked primary, surgical, and pain management teams to speak with the patient in more detail
- Physical therapy and occupational therapy can discuss plan for therapy
- Involve family in discussion

It is not about "making" the patient do one thing or another – it is about understanding the patient's thought process behind their decisions.


QUESTIONS?


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