Medication Evaluations for Mental Health: Coordination Between Primary Care and Psychotherapy

Medication evaluations are a central component of integrated mental health care. When conducted collaboratively between
Primary Care Providers (PCPs), psychotherapists, and—when indicated—psychiatrists, such evaluations improve diagnostic accuracy,
medication safety, adherence, and treatment outcomes. This document outlines the essential components, best practices, and
evidence-based frameworks supporting coordinated medication evaluations in mental health treatment.

1. Why Collaborative Medication Evaluations Matter

Collaborative care models have been empirically shown to improve depression and anxiety outcomes compared to usual care.
When PCPs and behavioral clinicians share information, utilize measurement-based tools, and maintain psychiatric consultation access,
patient outcomes—including symptom reduction, adherence, and quality of life—improve significantly (Gilbody et al., 2006; Reist et al., 2022).
Major practice guidelines from the National Institute for Health and Care Excellence (NICE, 2024) and the U.S. Department of Veterans Affairs (VA/DoD, 2022)
endorse this integrative approach for the management of mood and anxiety disorders.

2. Components of a Medication Evaluation

A medication evaluation in mental health should combine both medical and psychosocial perspectives. The PCP focuses on diagnosis,
medical safety, and pharmacological selection, while the psychotherapist offers behavioral insights and functional assessments.

- A. Structured Clinical Assessment (Baseline)

Use validated measurement-based tools such as:
- PHQ-9 for depression (Kroenke et al., 2001)
- GAD-7 for anxiety (Spitzer et al., 2006)
- C-SSRS for suicide risk (Posner et al., 2011)

A thorough evaluation includes medical and psychiatric history, family psychiatric history, medication interactions, and adherence barriers.
Screen for comorbid substance use, sleep disturbances, and risk factors for bipolar spectrum illness before prescribing antidepressants.

- B. Physical Exam and Laboratory Screening

Baseline labs and vitals help establish safety for psychotropic medications. For instance, BMI, blood pressure, fasting glucose, and lipid panels
are recommended before initiating second-generation antipsychotics (APA, 2020). Lithium requires baseline renal and thyroid panels and ECG if
cardiovascular risk is present (Gitlin, 2016).

- C. Shared Decision-Making

Medication selection should involve a transparent discussion of expected benefits, side effects, and alternative options.
Shared decision-making is associated with greater treatment adherence and satisfaction (NICE, 2024; AAFP, 2023).

3. Role Clarity Between PCP and Psychotherapist

- A. Primary Care Clinician

- Conducts diagnostic evaluation and prescribes medication within scope.
- Uses measurement-based care at every visit (PHQ-9, GAD-7).
- Monitors for side effects, metabolic changes, and suicidality.
- Consults psychiatry for complex or treatment-resistant cases.

- B. Psychotherapist

- Provides evidence-based psychotherapy (CBT, IPT, etc.).
- Monitors behavioral response, mood tracking, and adherence patterns.
- Communicates symptom changes, side effects, and psychosocial barriers to PCP.
- Participates in case reviews to ensure coordinated care.

4. Monitoring and Follow-Up

Ongoing assessment is vital for safety and efficacy. Measurement-based care should occur at regular intervals.

- 2–4 weeks: Review adherence, early side effects, and PHQ-9/GAD-7 scores.
- 4–6 weeks: Adjust dose or switch if <30% improvement.
- 8–12 weeks: Assess for remission or augmentation needs.

Maintenance therapy is generally recommended for 6–12 months after remission to prevent relapse (VA/DoD, 2022).

5. PCP–Psychotherapist Communication Workflow

Collaborative documentation enhances safety and treatment alignment. The psychotherapist's input regarding psychosocial stressors and functional gains is critical for the PCP's medication management decisions.

- Intake: Therapist provides diagnosis, PHQ-9/GAD-7 scores, and psychosocial context.
- Active treatment: Share updates every 2–4 weeks on progress, side effects, or stressors.
- Monthly review: Brief case review between PCP, therapist, and consulting psychiatrist (if applicable).

6. When to Refer to Psychiatry

Referral is indicated when there is diagnostic uncertainty, severe treatment resistance, complex polypharmacy, psychosis, bipolar disorder, high suicide risk, or perinatal medication management needs (VA/DoD, 2022; NICE, 2024).

References (APA 7th Edition)

- American Academy of Family Physicians. (2023). Pharmacologic treatment of depression. American Family Physician.
- American Psychiatric Association. (2020). Practice Guideline for the Treatment of Patients with Schizophrenia (3rd ed.).

- Gilbody, S., Bower, P., Fletcher, J., Richards, D., & Sutton, A. J. (2006). Collaborative care for depression: A cumulative meta-analysis. JAMA Internal Medicine.
- Gitlin, M. (2016). Lithium side effects and toxicity: Prevalence and management strategies. International Journal of Bipolar Disorders, 4(1), 27.
- Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. Journal of General Internal Medicine, 16(9), 606–613.
- National Institute for Health and Care Excellence. (2024). Depression in adults: Treatment and management (NG222).
- Posner, K., Brown, G. K., Stanley, B., et al. (2011). The Columbia–Suicide Severity Rating Scale (C-SSRS): Initial validity and internal consistency. American Journal of Psychiatry.
- Reist, C., Ewing, J., & Brooks, J. (2022). Collaborative mental health care: A narrative review. Cureus, 14(12), e32718.
- Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. Archives of Internal Medicine, 166(10), 1092–1097.
- U.S. Department of Veterans Affairs & Department of Defense. (2022). Clinical Practice Guideline for the Management of Major Depressive Disorder.