Mental Health and Wellness for Primary Care 2026

Thursday, May 7, 2026
Live Online via MS Teams

Target Audience
Primary care physicians, advanced practice nurses, physician assistants, and members of the health care team who seek to advance their knowledge in this area.

About the Course
This course provides primary care professionals with practical strategies and up-to-date knowledge for addressing mental health concerns. Through focused sessions and case-based discussions, participants will learn effective screening, diagnosis, and evidence-based interventions to enhance patient care in the primary care setting.

Agenda and Objectives
a.m.

8:35 - 8:45 **Welcome and Introduction** – Jackson Brammer, MD

8:45 - 9:30 **Primary Care Management of Anxiety Disorders** – Greg Simon, MD, MPH

- Review assessment and management of common anxiety disorders including assessment, pharmacotherapy, behavioral management in primary care, and collaborating with psychotherapists.

9:30 - 10:15 **Neuropsychological Testing in Primary Care** – Logan Wolff, PhD

- Cite the role of neuropsychological testing and its indications and the appropriate use of neuropsychological testing in primary care settings.

10:15 - 10:30 **Break**

10:30 - 11:15 **Adult Attention Deficit Hyperactivity Disorder (ADHD)** – Alison Deem, MD

- Discuss adult ADHD, including new evaluation methods and potential treatment pathways.

11:15 - 12:00 **Adult Autism & Psychology Updates** – Samantha Jimenez, PsyD and Phil Ullrich, PhD

- Discuss the importance of adult autism assessment and how primary care providers can effectively manage these conversations and provide an overview of the treatment pathway.

p.m.

12:00 - 12:45 **Lunch**

12:45 - 1:30 **Psychiatry Quick Care Guides Updates, E-consultation, and Collaborative Care** – Jake Pounds, MD

- Cite QCG's role in supporting primary care providers with mental health management.
- Review the collaborative care program at KPWA including its reception, feedback, and outcomes.

1:30 - 2:15 **Post Traumatic Stress Disorder (PTSD) Diagnosis and Treatment** – Benjamin Balderson, PhD and Greg Simon, MD, MPH

- Discuss PTSD diagnosis using PCL-5, trauma-informed care principles, pharmacotherapy options for PCPs, and evidence-based psychotherapies including CPT, PE, and EMDR.

2:15 - 2:30 **Break**

2:30 - 3:15 **Bipolar Disorder Maintenance Treatment** – Stanley Shyn, MD, PhD

- Discuss the maintenance of bipolar disorder, identify symptoms, and explore collaboration opportunities between primary care and psychiatry. (Expectations in PC after Pt stable.)

3:15 - 4:00 **Management of Peripartum Mood and Anxiety Disorders** – Natalie Wolff, MD

- Assess and appropriately treat peripartum mood disorders, including OCD and depression.

4:00 - 4:45 **Group Q&A –** all, facilitated by Jackson Brammer, MD

4:45 **Adjournment**

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Tuition
Tuition includes all educational sessions, electronic course syllabus and all applicable tax. You will receive written confirmation of your registration.

Kaiser Permanente Staff: $175
Community Attendees: $195

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Primary care management of anxiety disorders

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May 7, 2026

I have no financial interests or other conflicts to disclose

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Assessment and management of anxiety disorders: Outline

- Classification of anxiety disorders
- Initial assessment
- Substance use
- Measurement-based care
- Pharmacotherapy
- Behavioral management for primary care
- Collaborating with psychotherapists
- Simple phobias

Good general reference:

Clinical Review & Education

JAMA | Review

Anxiety Disorders
A Review

Kristin L. Szuhany, PhD; Naomi M. Simon, MD, MSc

IMPORTANCE Anxiety disorders have a lifetime prevalence of approximately 34% in the US, are often chronic, and significantly impair quality of life and functioning.

OBSERVATIONS Anxiety disorders are characterized by symptoms that include worry, social and performance fears, unexpected and/or triggered panic attacks, anticipatory anxiety, and avoidance behaviors. Generalized anxiety disorder (6.2% lifetime prevalence), social anxiety disorder (13% lifetime prevalence), and panic disorder (5.2% lifetime prevalence) with or without agoraphobia are common anxiety disorders seen in primary care. Anxiety disorders are associated with physical symptoms, such as palpitations, shortness of breath, and dizziness. Brief screening measures applied in primary care, such as the Generalized Anxiety Disorder–7, can aid in diagnosis of anxiety disorders (sensitivity, 57.6% to 93.9%; specificity, 61% to 97%). Providing information about symptoms, diagnosis, and evidence-based treatments is a first step in helping patients with anxiety. First-line treatments include pharmacotherapy and psychotherapy. Selective serotonin reuptake inhibitors (SSRIs, eg, sertraline) and serotonin-norepinephrine reuptake inhibitors (SNRIs, eg, venlafaxine extended release) remain first-line pharmacotherapy for generalized anxiety disorder, social anxiety disorder, and panic disorder. Meta-analyses suggest that SSRIs and SNRIs are associated with small to medium effect sizes compared with placebo (eg, generalized anxiety disorder: standardized mean difference [SMD], −0.55 [95% CI, −0.64 to −0.46]; social anxiety disorder: SMD, −0.67 [95% CI, −0.76 to −0.58]; panic disorder: SMD, −0.30 [95% CI, −0.37 to −0.23]). Cognitive behavioral therapy is the psychotherapy with the most evidence of efficacy for anxiety disorders compared with psychological or pill placebo (eg, generalized anxiety disorder: Hedges g = 1.01 [large effect size] [95% CI, 0.44 to 1.57]; social anxiety disorder: Hedges g = 0.41 [small to medium effect] [95% CI, 0.25 to 0.57]; panic disorder: Hedges g = 0.39 [small to medium effect[[95% CI, 0.12 to 0.65]), including in primary care. When selecting treatment, clinicians should consider patient preference, current and prior treatments, medical and psychiatric comorbid illnesses, age, sex, and reproductive planning, as well as cost and access to care.

CONCLUSIONS AND RELEVANCE Anxiety disorders affect approximately 34% of adults during their lifetime in the US and are associated with significant distress and impairment. First-line treatments for anxiety disorders include cognitive behavioral therapy, SSRIs such as sertraline, and SNRIs such as venlafaxine extended release.

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Multimedia

Supplemental content

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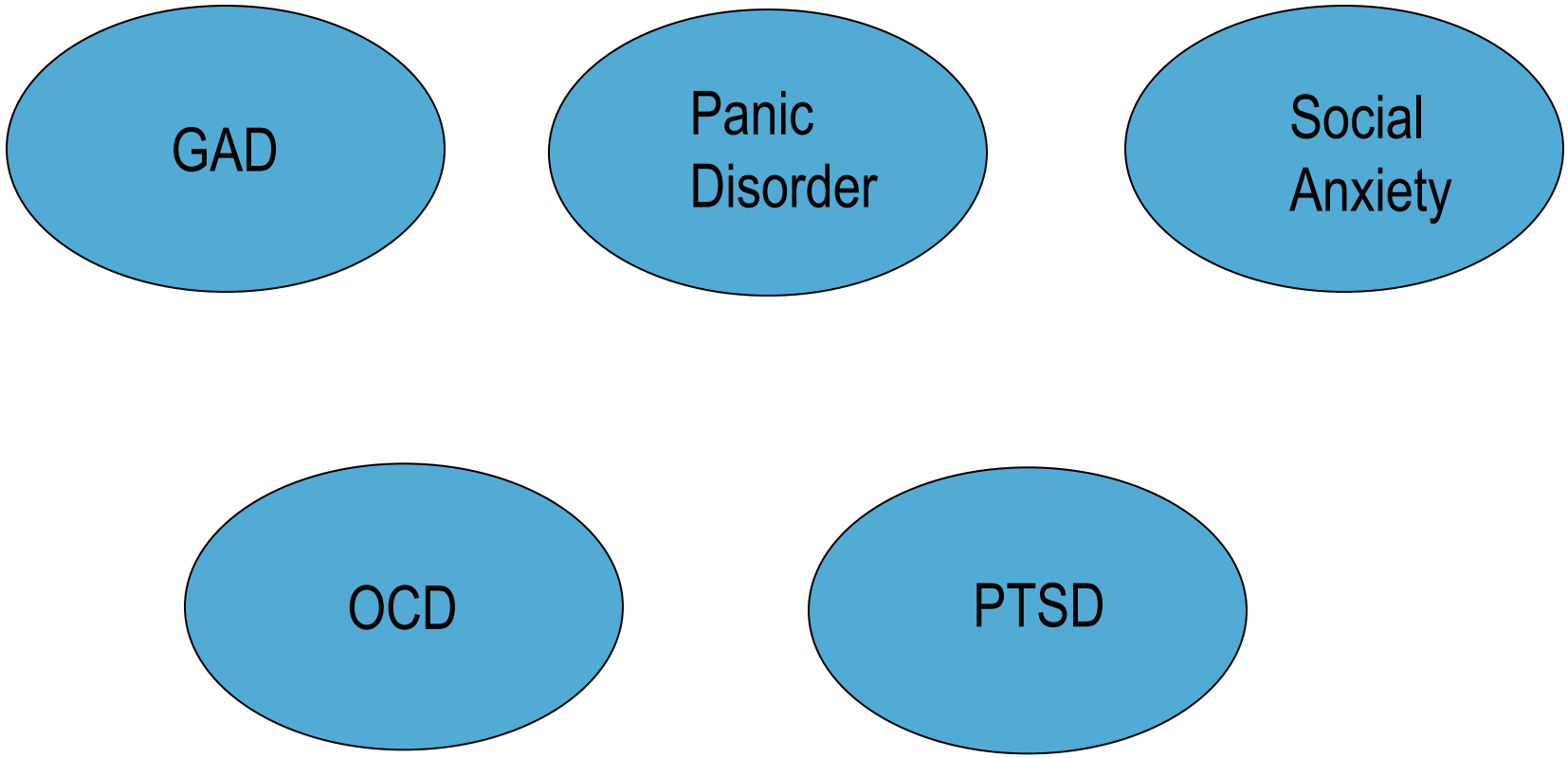
Basic epidemiology

- Annual prevalence 15% or more (higher in primary care patients)
- Lifetime prevalence 30% or more
- More common in females than males
- Most common onset in early teens, but may be earlier
- Often accompanied by depressive disorder and/or substance use disorder

Anxiety disorders according to DSM-5



Anxiety disorders in reality

Irritability

Avoidance

Palpitations

Worry

Nightmares

Intrusive thoughts

Insomnia

Abdominal pain

Shortness of breath

Hypervigilance

Rituals & Compulsions

Flashbacks

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Core features of anxiety disorders

- GAD
  - Excessive worry and tension (often with somatic symptoms)
  - Nearly always present (but varies in severity)
- Panic Disorder
  - Sudden (often unprovoked) severe anxiety with prominent somatic symptoms
  - Often accompanied by phobic avoidance
- Social Anxiety
  - Anxiety focused on social situations – “being paid attention to”
- OCD
  - Compulsive behaviors or rituals, intrusive or disturbing thoughts’
  - Cycle of anxiety and (temporary) relief
- PTSD
  - Follows traumatic or disturbing event (s)
  - Trio of re-experiencing, hypervigilance, and avoidance

Assessment – Identifying most important symptoms

- GAD: Is it the kind of anxiety that's nearly always there, not related to any specific situation?
- Panic disorder: Do you have attacks of severe anxiety, sometimes for no reason, that come on quickly and last for only an hour or so?
- Social anxiety: Does the anxiety mostly occur in social situations or situations where people might be paying attention to you
- OCD: Do you have unusual or disturbing thoughts that make no sense but make you very anxious? Do you feel compelled to do rituals or checking behaviors and feel very anxious if you don't?
- PTSD: Does the anxiety focus on traumatic or upsetting things that have happened to you? Do you have nightmares or flashbacks about those experiences?

Assessment – Co-occurring mental health conditions

- Depression: Use PHQ-9!
- Bipolar disorder: Do you sometimes have mood swings where for several days you feel speeded up and have an unusually high level of energy? Has a doctor or therapist ever said they thought you had bipolar disorder or manic depressive illness?

  (The Mood Disorders Questionnaire may be useful for screening, but it is not very specific – lots of false positives - especially outside of mental health specialty care)

Assessment – Substance use

- Alcohol use: Use AUDIT-C
- Cannabis use: If more often than weekly, use substance use disorder checklist

Assessment – Somatic symptoms

- History and physical exam often sufficient
- Labs, imaging, and other diagnostic testing can be reassuring, but can sometimes reinforce anxiety/checking cycle
- Consider the prior probabilities

Measurement-based care for anxiety

- GAD-7 is reasonable measure across anxiety disorders
- Condition-specific measures (e.g. PCL) can sometimes be helpful – but usually don't need multiple measures for every type of symptom
- GAD-7 scores as rough guide to treatment planning:
    - 0 to 4 (minimal): reassura;nce, and advice in primary care
    - 5 to 9 (mild): brief behavioral interventions, maybe collaborative care
    - 10 to 14 (moderate): medication may be indicated, collaborative care or MHW referral
    - <=15 (severe): medication likely indicated, MHW referral

Alcohol

- Anxiety often accompanied by unhealthy alcohol use or alcohol use disorder
- Optimal amount of alcohol use is zero, but certainly no more than 1/day and 2/week
- Important to acknowledge perception that alcohol is helpful
  - Short term anxiety reduction is obvious
  - Longer-term anxiety exacerbation is usually not
- Other treatments can still be effective if alcohol use persists – but not as effective
- Alcohol use can undermine behavioral treatments (more on that later)

Cannabis

- Not effective for treatment of anxiety disorders
- May contribute to or worsen anxiety in some people
- Cannabis use disorder can coexist with anxiety disorder, and should be addressed

Caffeine

- May contribute to anxiety in some people
- Brief trial of reducing or abstaining can be helpful

Pharmacotherapy for anxiety disorders

- SSRIs and SNRIs are first-line
- Benzodiazepine use should be rare
- Off-label medications (hydroxyzine, gabapentinoids) have limited role

(OCD may be different – more on that later)

FDA-approved indications for anxiety disorders

	GAD	Panic	OCD	Social Anxiety	PTSD
Sertraline		✓	✓	✓	✓
Escitalopram	✓				
Fluoxetine		✓	✓		
Paroxetine	✓	✓	✓	✓	✓
Citalopram					
Venlafaxine	✓	✓		✓	
Duloxetine	✓				
Fluvoxamine			✓	✓	
Clomipramine			✓		
Buspirone	✓				

FDA-approved indications for anxiety disorders

	GAD	Panic	OCD	Social Anxiety	PTSD
Sertraline		$	$	$	$
Escitalopram	$				
Fluoxetine		$	$		
Paroxetine	$	$	$	$	$
Citalopram					
Venlafaxine	$	$		$	
Duloxetine	$				
Fluvoxamine			$	$	
Clomipramine			$		
Buspirone	$				

Which SSRI/SNRI?

No clear difference in average efficacy, moderate differences in average tolerability

- Best tolerability: escitalopram, fluoxetine, sertraline
- Medium tolerability: venlafaxine, duloxetine, paroxetine
- Least tolerability: fluvoxamine, clomipramine

(Anxiety may increase sensitivity to or attention to side effects)

Starting SSRIs and SNRIs

- Starting dose for 5 to 7 days
- Secure message or phone check-in (mostly about side effects)
- If no significant side effects at 5-7 days, increase to low end of effective range
- Visit to assess effectiveness after another 3 weeks
- If not sufficiently effective but no significant side effects, increase to moderate dose
- Assess effectiveness after another 3 weeks

Dosing of SSRIs and SNRIs for anxiety disorders

	Starting	Low	Moderate	High
Sertraline	25mg	50mg	100mg	200mg
Escitalopram	5mg	10mg	15mg	20mg
Fluoxetine	5mg	10mg	20mg	40mg
Paroxetine	10mg	20mg	30mg	40mg
Venlafaxine	37.5mg	75mg	150mg	225mg
Duloxetine	20mg	40mg	60mg	90mg

OCD may be a bit different

- Fluvoxamine and (especially) Clomipramine may be more specifically effective
- Higher doses of more common medications may be needed (e.g. 60mg of fluoxetine)

PTSD is a bit different

More on that later

What about buspirone?

- FDA approved for treatment of GAD
- Intended to be taken regularly (NOT as needed)
- Recommended dosing is bid, but evening only works for some
- Onset of action more like SSRIs and SNRIs (not like benzodiazepines)
- Does NOT prevent or reduce benzodiazepine withdrawal
- Dosing schedule:
  - 10mg qhs to start
  - If no adverse effects after one week, increase to 10mgbid
  - If no adverse effects and inadequate benefit after 2 weeks, can increase to 15mg bid

Second-line treatment

- If first-line SSRI or SNRI not tolerated, switch to alternative
- If first-line SSRI or SNRI not effective, two reasonable options:
  - Switch to alternative as above
  - Augment with buspirone as above

Switching SSRIs/SNRIs

- Usually “cross-taper”, especially when switching away from medication with short half-life (venlafaxine, paroxetine)
- Overlap in 3 or more steps, about a week apart:
  - Sertraline 150mg/day
  - Sertraline 100mg/day and Duloxetine 20mg/day
  - Sertraline 50mg/day and Duloxetine 40mg/day
  - Duloxetine 60mg/day
- Check in by messaging at each step
- If discontinuation symptoms (tinnitus, dizziness, “brain zaps”), slow down

What's the appropriate role of benzodiazepines

- Low dose, infrequent, and short term (e.g. #7 lorazepam 0.5mg to last one month)
- Lorazepam has moderate duration of action (alprazolam too short, clonazepam usually too long)
- The most effective lorazepam is the one you never take ("enough to know it's there")
- Set clear expectations:
  - No early refills
  - If you have every day anxiety, you may need an every day medication
  - If you tell me you need more, I'll know that you need less

Tapering benzodiazepines

- You may not have made this mess, but you still need to deal with it
- Clearly describe risks of long term use (worsening anxiety, hastening cognitive impairment, falls and fractures)
- Offer effective treatment (SSRIs and SNRIs, psychotherapy) but framed as more effective treatment rather than an ultimatum)
- Set clear expectations:
    - Specific time period
    - No early refills
    - Each reduction may cause some increase in anxiety, but that will settle down
- Tapering off long-term benzodiazepine treatment may take 3-6 months with one decrease each month
- Think of reductions as proportions rather than # of mg (e.g. reducing daily dose by f 50% each month rather than reducing by 0.5mg per month)
- May sometimes need to switch to benzodiazepines allowing smaller dosing increments (clonazepam, diazepam)

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Off-label medications

- Hydroxyzine
  - Often prescribed PRN as alternative to benzodiazepines
  - Typical dose 25-50mg (maximum 100mg)
  - Less concern about tolerance/dependence
  - BUT can have significant anticholinergic side effects
  - Definitely avoid in elderly
- Gabapentin
  - Sometimes prescribed PRN and sometimes on fixed tid schedule
  - Duration 3-4 hrs
  - Typical dose 300-600mg (maximum 900mg)
  - Tolerance is common, but dependence less of a concern
- Beta-blockers (most often propranolol)
  - Usually prescribed PRN (often for performance anxiety or social situations)
  - Most helpful with somatic symptoms of anxiety (palpitations, tremors)
  - Duration 3-4 hrs
  - Typical dose 10-20mg (max 40mg)
  - No concerns with tolerance or dependence
  - Can cause hypotension

Nutritional supplements (primarily for anxiety symptoms or GAD)

- Omega-3 fatty acids (fish oil): Low certainty of evidence for modest benefit
- Probiotic supplements: Moderate certainty of evidence for small benefit
- Kava: Moderate certainty of evidence for small benefit
- N-acetyl cysteine: Moderate evidence specific to OCD

My view: Would not recommend any as primary or stand-alone treatments for more severe anxiety disorders

Psychedelic treatment for anxiety disorders

- Ketamine/Esketamine
  - Esketamine approved (and sometimes insurance-covered) for treatment-resistant depression – but not for anxiety
  - Ketamine-assisted psychotherapy is legal (off-label) and sometimes provided for treatment-resistant anxiety – but not covered by insurance
  - Be wary of free-standing (sometimes strip-mall) ketamine clinics
- Other psychedelics (Psilocybin, MDMA, LSD, Ayahuasca)
  - None approved by FDA or covered by insurance
  - Generally accompanied by psychotherapy or “guidance” – but that can vary widely
  - Psilocybin legalized in Colorado and Oregon (But lots of things that are legal are still not good for you!)
  - My view – only in a legitimate clinical trial
- Regarding PTSD – more later

Behavioral management for primary care

- Reducing excess arousal
- Taming anxious thoughts
- Overcoming avoidance

Reducing excess arousal

- Many paths to the same goal
  - Breathing exercises, visualization, meditation – what's most effective for one person can be off-putting for the next
  - Explicit spiritual component may be helpful – or maybe not
  - Community or social component may be helpful – or maybe not
- Numerous eHealth resources
  - Calm and Headspace apps both available to KP members
- Regular practice is the key (that's why they call them "exercises")
- Physical activity can help to reduce overall arousal and desensitize to physical sensations of arousal

Taming anxious thoughts

- Recognition is the first step
- Cognitive therapy – the rational approach
  - Write them down (helps create distance)
  - Consider the evidence
  - Develop and try out “reasonable” responses
  - Practice in calmer times to build skills and confidence to use when anxiety is high
- Mindfulness – the spiritual approach
  - Goal is not to defeat or overcome anxious thoughts, but to disengage
  - “Self-compassion” is often a useful construct

Overcoming avoidance

- Planned, graded exposure
- Focus on something that would bring joy or satisfaction
- Goals defined in time or task, not governed by anxiety level (“You control the anxiety, it doesn’t control you.”)
- Repeat each step until it doesn’t cause anxiety, then go to next step
- For health anxiety: focus on checking rituals

Recommended reading

- GAD: Mastery of Anxiety and Worry (Michelle Craske and David Barlow)
- Panic: Mastery of Anxiety and Panic (David Barlow and Michelle Craske)
- OCD: Stop Obsessing (Edna Foa)

Recommending or referring to psychotherapy

- Psychotherapy is first-choice treatment for moderate or severe anxiety disorders (with medication added on)
- Effective psychotherapy is about “skills, not secrets”
- Preview the essential ingredients of effective psychotherapy for anxiety:
  - Reducing arousal to reduce physical symptoms
  - Recognizing and taming anxious thoughts
  - Building tolerance of feared situations
- There will be (or should be) homework, and that’s good news

Checking in about psychotherapy

- How often have you been meeting with your therapist?
- What sorts of things do you talk about or work on?
- Are you learning skills that help to manage anxiety
- (If you have concerns) Let me suggest a book you could read – and discuss with your therapist

Tapering SSRIs and SNRIs

- When
  - Symptoms in remission or minimal for 6 months
  - No major stresses current or anticipated
- How
  - Identify signs of relapse
  - Reduce in 3 or more steps, at least one month apart
  - Check in (could be phone or messaging) before each reduction

SSRI/SNRI discontinuation reactions

- Common, but usually not severe or prolonged
- Most common with shorter half-life (paroxetine, venlafaxine)
- Important to distinguish from relapse of anxiety or depression
- Before tapering or switching medications, ask “Do you notice problems if you miss a day or two?”
- If severe or prolonged (10-15% of people tapering):
  - Back up and go more slowly
  - Remember about proportional reductions
  - May sometimes need to switch to drug with longer half-life, especially fluoxetine

Simple phobias

- Often accompany other anxiety disorders – consider as a target symptom for overall treatment
- Sometimes occur in isolation
- When isolated, pharmacotherapy not usually indicated
- Same approach for overcoming avoidance
  - Planned, graded exposure
  - Focus on something that would bring joy or satisfaction
  - Goals defined in time or task, not governed by anxiety level (“You control the anxiety, it doesn’t control you.”)
  - Repeat each step until it doesn’t prompt anxiety, then go to next step.

Questions?

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Neuropsychological Testing in Primary Care

Presenter:

Logan Wolff, PsyD, ABPP (she/her)
Board Certified Clinical Neuropsychologist

Mental Health and Wellness for Primary Care 2026

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A Bit About Me!

- Florida→Texas→Washington
- Worked at KP since 2019
- Located in Capitol Hill MHW Clinic
- See patients 18-100+ years old

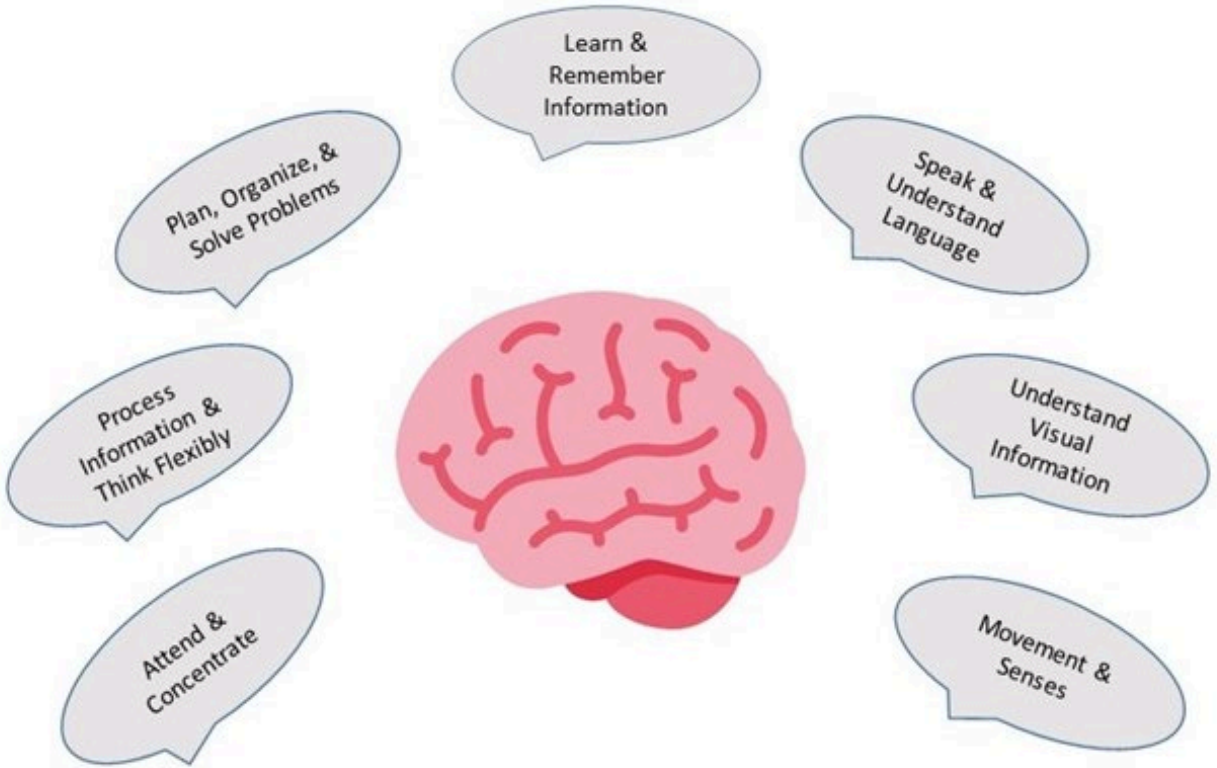
Agenda

- Review what is entailed in an adult/older adult neuropsychological evaluation
- Highlight the benefits and discuss how we can support providers and patients
- Identify when you should refer to us

Objectives

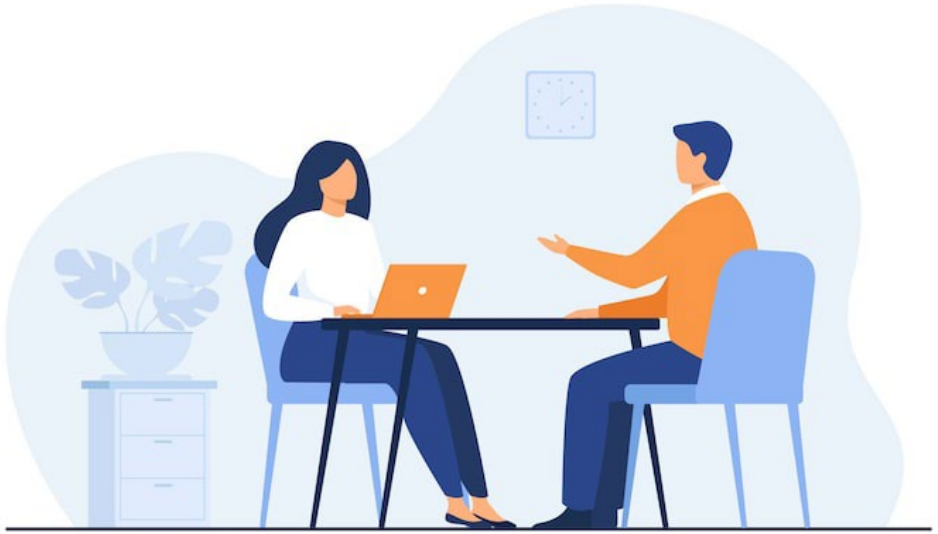
- Cite the components of a neuropsychological evaluation
- Determine which patients may benefit from our services
- Identify when and how to refer to us

The Neuropsychological Evaluation



Interview

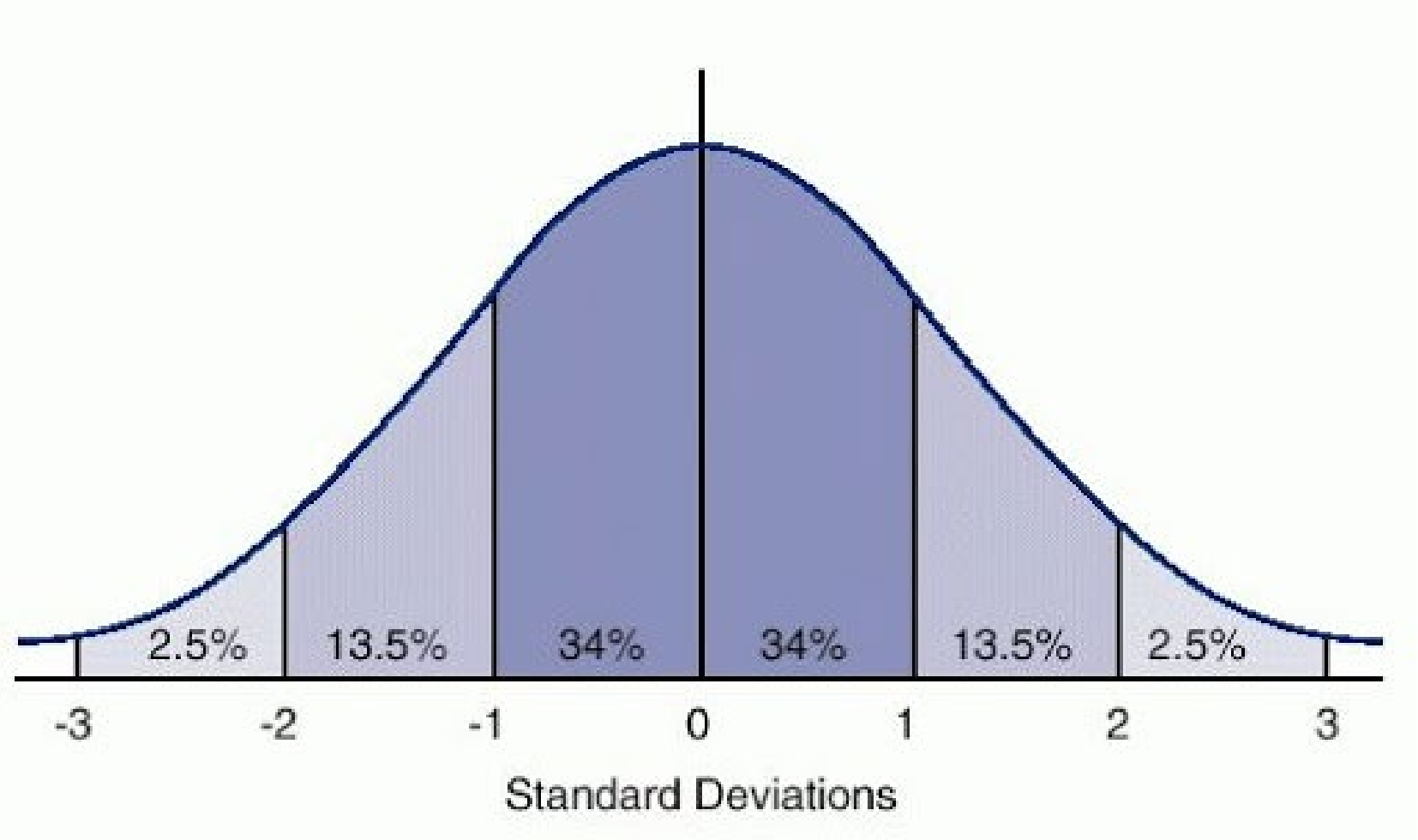
- Records review
- Patient and collateral reports of current cognitive, emotional, motor, and ADL functioning
- Gather relevant history
  - Developmental
  - Educational
  - Occupational
  - Social
  - Medical
  - Mental Health
  - Substance Use
- Cognitive screener



Testing

- Effort/Validity
- Pre-morbid Abilities
- Language
- Visual Skills
- Memory (verbal and visual)
- Attention (simple and complex)
- Processing Speed
- Executive Functioning
- Motor
- Mood

Scoring

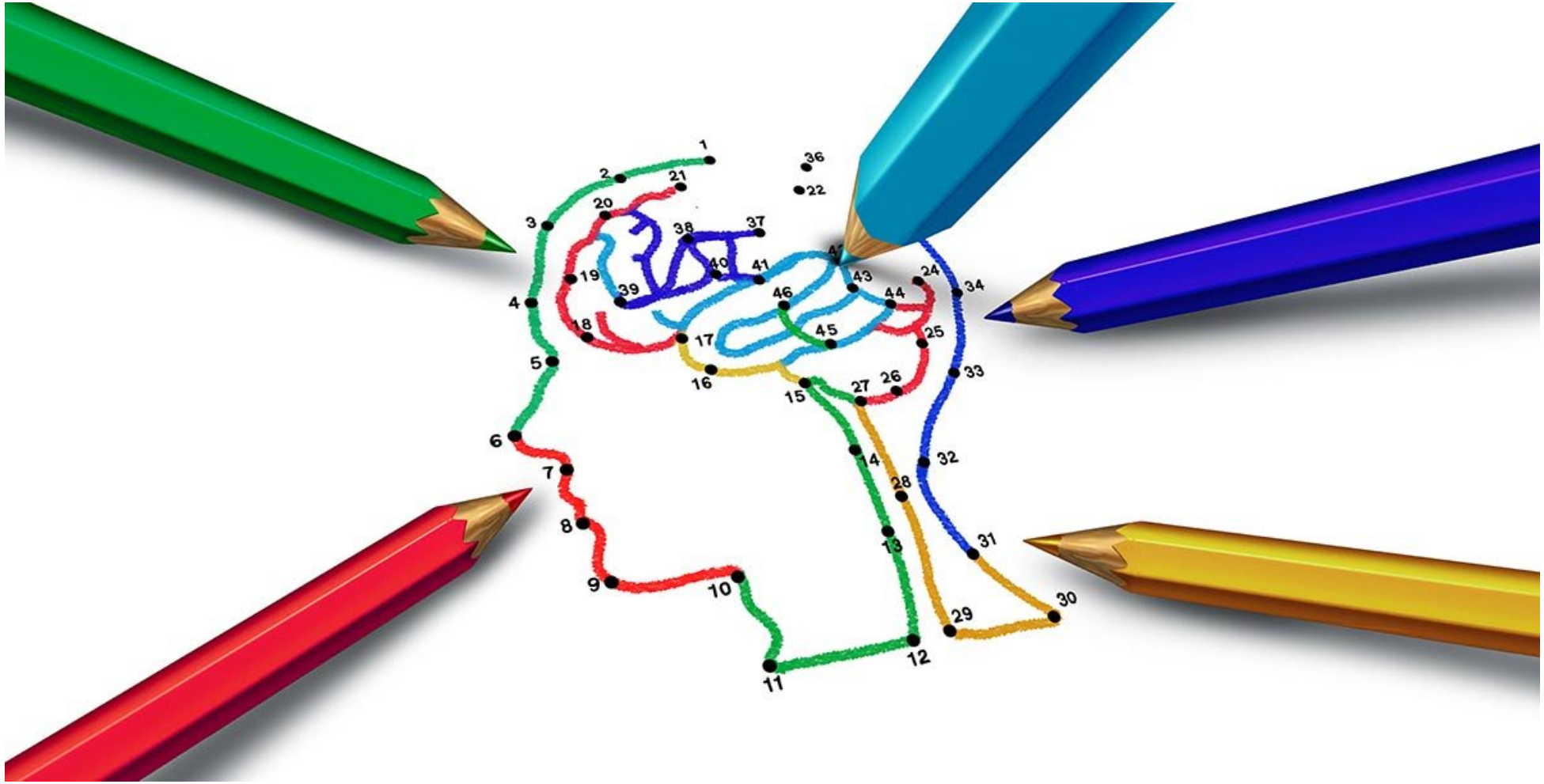


Feedback

Total Time

- Interview: 1ish hours
- Testing: 1-2 hours for older adults (or more if highly educated), 3-4 hours for adults
  - Not “one size fits all”, use tests to fit the needs of the patient
- Feedback: 1ish hours
- Report Writing: the limit does not exist
- Usually appointments are not all done on the same day

How Can A Neuropsychological Evaluation Help?



What We Can Do

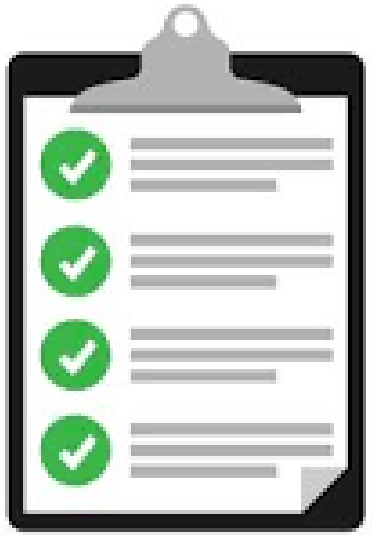
- Determine if a patient is having cognitive deficits that are more than normal aging alone
  - Integrate baseline intelligence factors
  - Use education corrected normative data
- Assess if a patient is having persistent deficits after a stroke, TBI, etc.
- Characterize the degree of cognitive impairment in a known neurological condition (e.g., seizure, Parkinson's disease, MS)
- Diagnose (e.g., MCI vs. dementia/mild neurocognitive disorder vs. major neurocognitive disorder)
- Determine staging/severity of dementia (mild, moderate, severe)

What We Can Do

- Discuss etiological considerations:
  - Review if there is suspicion for a neurodegenerative process (e.g., AD)
  - Identify certain patterns/profiles that could support one condition (e.g., AD) vs. another (e.g., LBD)
  - Assess for less common forms of dementia (e.g., PPA, PCA)
- Have a discussion with patient/family regarding diagnosis
- Recommend next steps

Recommendations Could Include…

- Medication/Treatment Options *deferred entirely to treating providers*
- Neurology/Imaging
- Psychiatry/Counseling
- Substance Use Discussion
- Sleep Hygiene/Sleep Apnea Discussion
- Updated Vision/Hearing Evaluations
- Driving Recommendations/Evaluation



Recommendations Could Include…

- ADL Supports
- Future Planning
- Caregiver Support/Resources
- Compensatory Strategies/Referral to SLLS for ongoing therapy if indicated
- Physical/Mental/Social Activity
- Nutrition
- Re-Evaluation (1+ years)

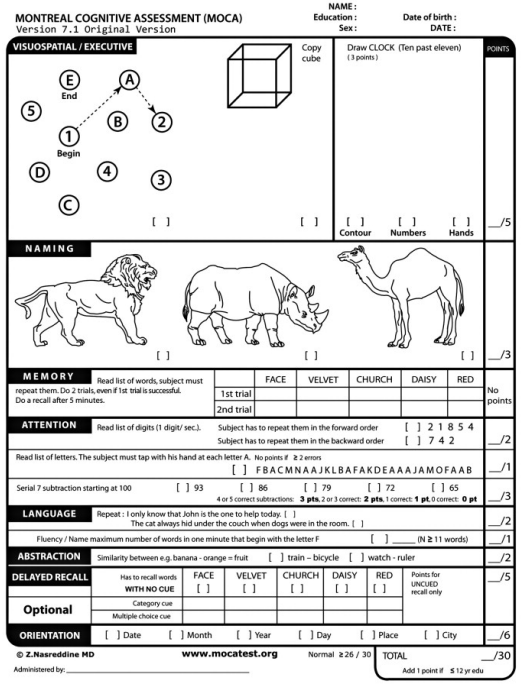
What We Cannot Do

- Cognitive rehabilitation
- Determine decision making capacity
- Prescribe medications
- Diagnose ADHD & ASD (this is for Psychology department)
- Have regular follow-up (except for 1+ year re-evals)

When to Refer?

When To Refer to Neuropsychology

- MoCA score between 10-17 (for MOCA of 9 or below testing is not indicated; rule out medical causes per the QCG and proceed with diagnosis)
- MoCA score between 18-25 with low functioning ADLs
- MoCA score between 18-25 with high functioning ADLS and very high level of education/pre-morbid functioning



When To Refer to Neuropsychology

- Do not need to always base it on the MoCA
- Rapid/sudden onset of cognitive changes
- Atypical symptoms:
  - Behavioral/mood changes in the absence of significant psychiatric history
  - New onset of hallucinations (especially in an older adult)
  - Unusual speech or vision changes
  - Established neurological condition (e.g., Parkinson's disease, MS, epilepsy) with increased cognitive changes (e.g., MoCA declines)

When To Refer to Neuropsychology

- Moderate/Severe TBI
  - Not mild TBI/concussion, unless positive neuroimaging findings (i.e. mild complicated TBI)
- CVA/other brain insult with symptoms > 6 months
- Abnormal neuroimaging (e.g., CAA, tumor, severe white matter changes)
- Very high or very low education or baseline intelligence
- Pre- and post- brain surgery evaluations (e.g., tumor resection, DBS)

When To Refer to Neuropsychology

- (QCG being updated)
- Huddle Card→
  - 2026 Psychology Changes
- Capitol Hill & Tacoma
- No changes to child neuropsychology

Refer to Psychology for neuropsychological testing regarding adult cognitive concerns (dementia/other neurocognitive disorder) if:

- MOCA score between 10-17 (for MOCA of 9 or below testing is not indicated; rule out medical causes per the QCG and proceed with diagnosis)
- MOCA score between 18-25 with low functioning ADLs
- MOCA score between 18-25 with high functioning ADLS *and* very high level of education/pre-morbid functioning
- Rapid/sudden onset of cognitive changes
- Atypical symptoms:
  - Behavioral/mood changes in the absence of significant psychiatric history
  - New onset of hallucinations (especially in an older adult)
  - Unusual speech or vision changes
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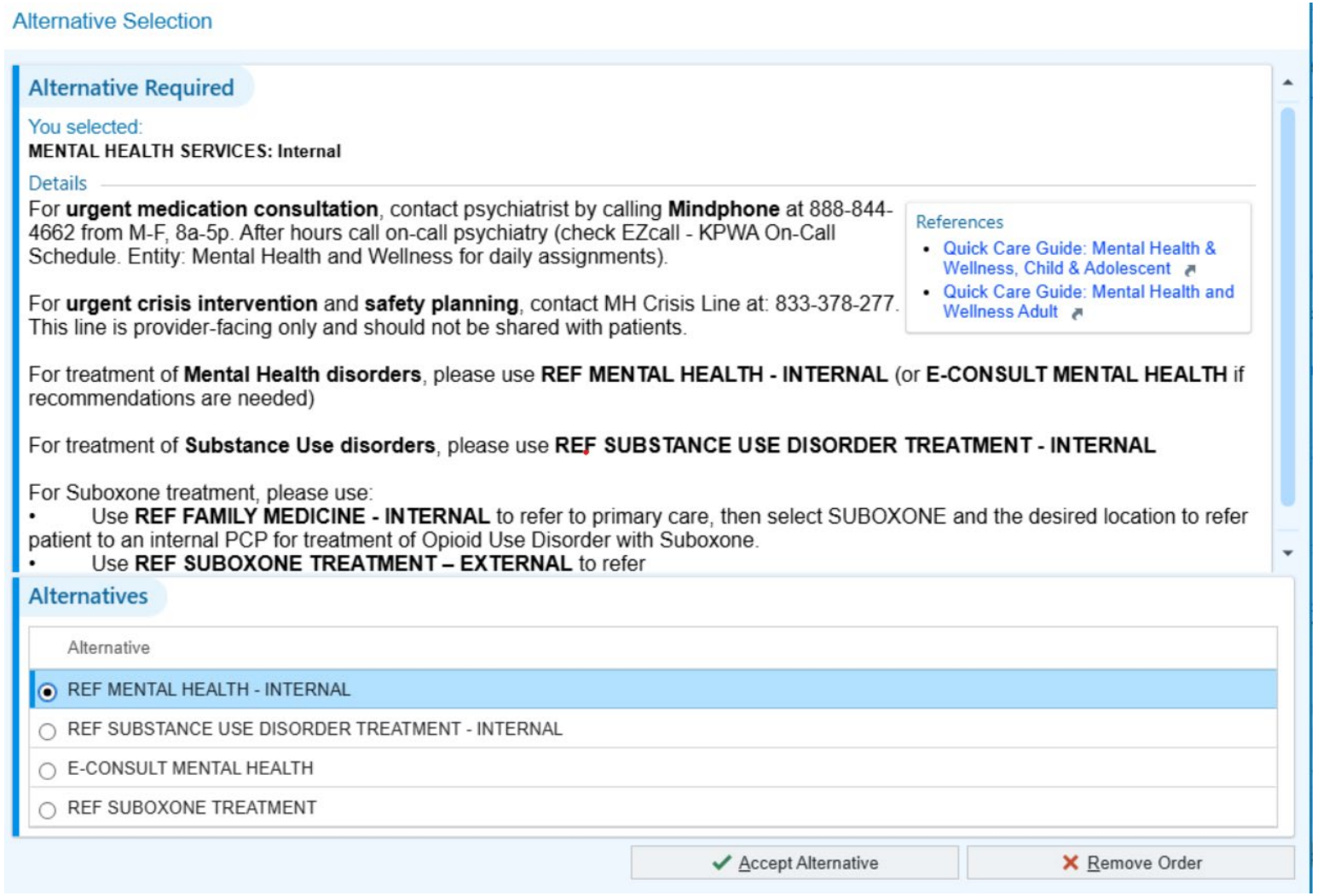
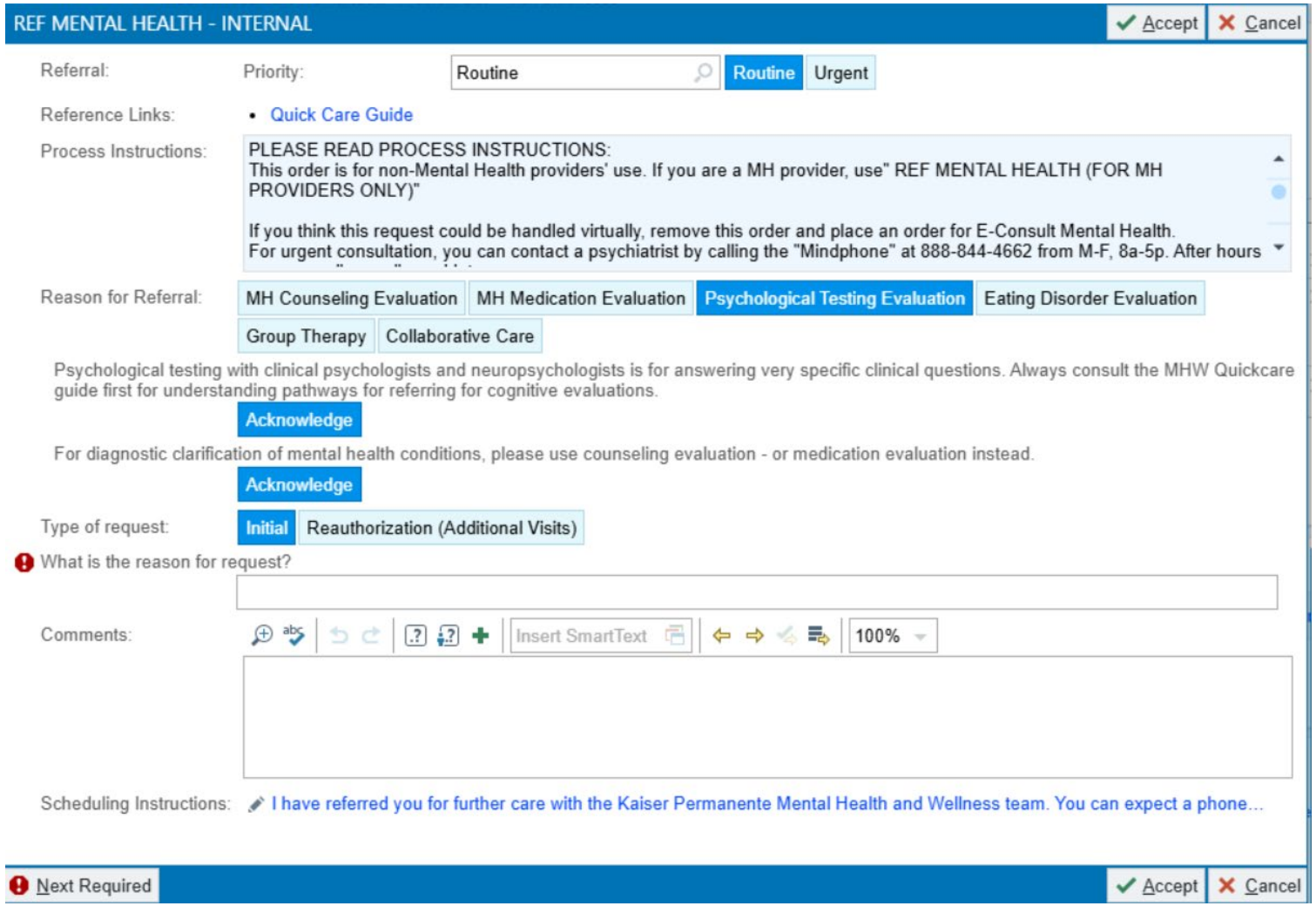
- Pre- and post- brain surgery evaluations (e.g., tumor resection, DBS)

How To Refer To Neuropsychology



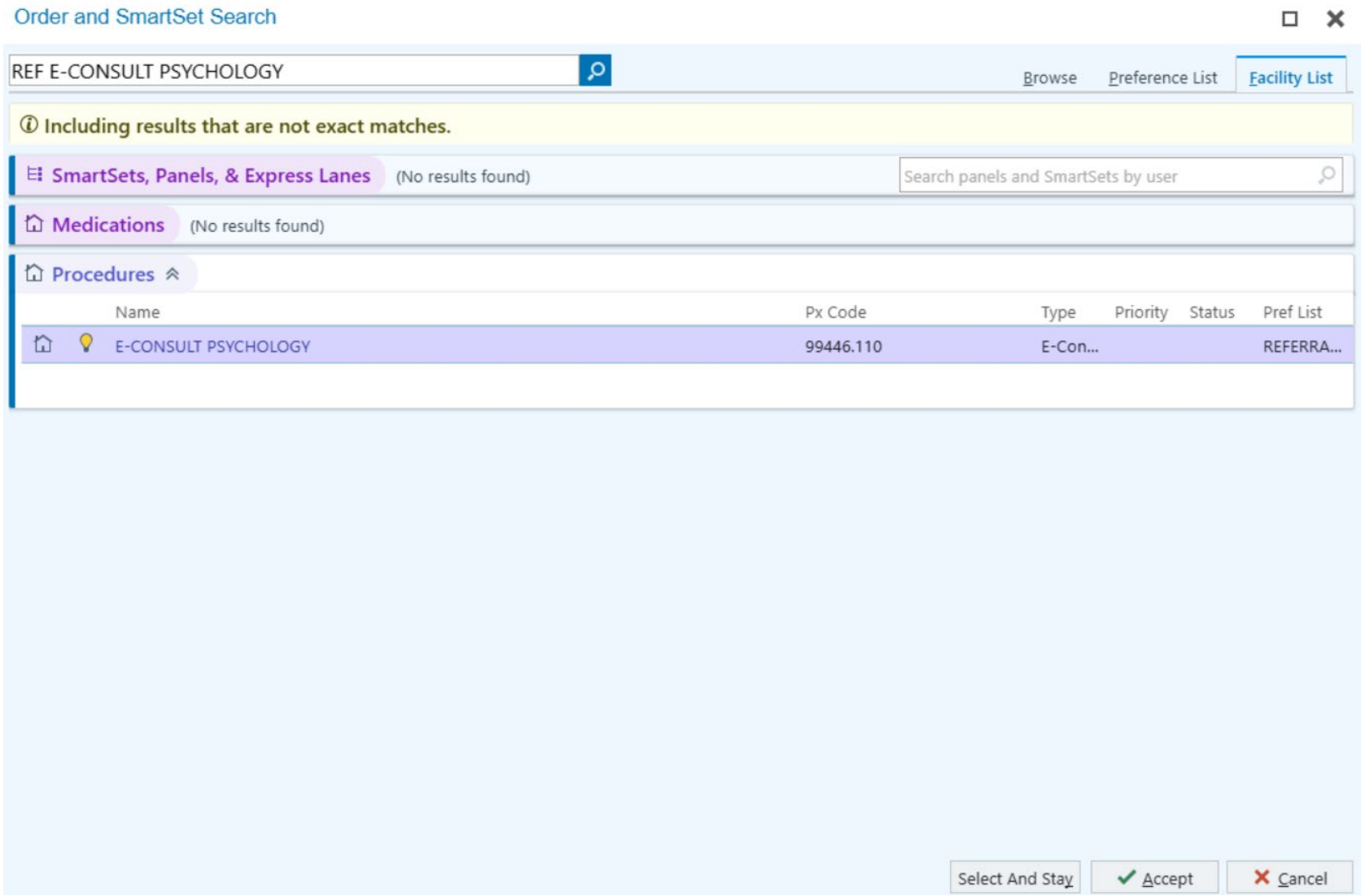
How To Refer To Neuropsychology



SLLS Considerations

- MOCA scores of 18-25 with high functioning ADLS
- Post-concussion cognitive evaluation
- Need for cognitive retraining techniques or ongoing therapy
- SLLS is not able to formally diagnose
- If MoCA or SLUMS are grossly abnormal or if presentation indicates marked memory disturbance and diagnosis is clear, no need for SLLS evaluation and patient can be managed in Primary Care
- Huddle Card
  - 2026 Psychology Changes

What If You Are Not Sure?



Case Examples

Case #1

- 72-year-old woman accompanied by her husband. She is a former UW professor who says she is “fine”. Her husband has been noticing more memory loss in her over the past several years, which he says contributed to her retirement (she disagrees). She is reportedly able to manage her medications and appointments. Her husband has always managed the finances. He usually drives when they are together. No hygiene concerns. MoCA was 25/30 (0/5 delayed memory).

Case #2

- 46-year-old man presents alone. He had a mild TBI several years ago (neuroimaging negative). He has noticed more cognitive changes recently. He also describes work stress and he is going through a divorce. Unremarkable family history. Not enough time to complete a MoCA.

Case #3

- 63-year-old man who presents with his daughter. He is an accountant. His daughter has noticed behavioral changes in him recently, such as him saying inappropriate things at family gatherings. He also has been spending more money, and recently bought a new sports car, which is unlike him. Psychiatric history was denied. His daughter was unsure about his ADLs. MoCA 26/30 (poor trails, clock, and serial subtractions).

Thank You!

ADULT ADHD - ATTENTION DEFICIT HYPERACTIVITY DISORDER

Alison Deem, MD

Staff Psychiatist, Tacoma

5/7/26

OBJECTIVES

- Review the epidemiology of adult ADHD
- Establish the diagnostic approach
  - DSM-5 diagnostic criteria for Adult ADHD
- Identify potential treatment pathways
- Clarify when and how to refer to Mental Health

- No conflicts of interest

ADULT ADHD

- 2-5% adults worldwide
- 15.5 million adults in US
- Third to half of children meet criteria as adult
- Differs from ADHD in children
  - Less hyperactivity
  - Hyperactivity may appear as restlessness

Strengths	Adverse Consequences
Hyperfocus	Relationship problems
Curiosity	Inconsistent performance at work
High levels creativity / innovation	Difficulties with day-to-day responsibilities
Rapid problem-solving skills	Chronic feelings of low self-worth, frustration, guilt or blame
Spontaneous, quick thinking	Health outcomes
High energy	
Risk takers	

ADULT ADHD

High heritability

- Heritability is approximately 74% (no single gene)
- Sibling with ADHD, 32% chance of having ADHD
- Parent with ADHD, 57% chance

Prevalence affected by cultural variation in attitudes toward behavioral norms

- Rates lower in black and Latinx populations

More frequent in males, ratio of 1.6:1

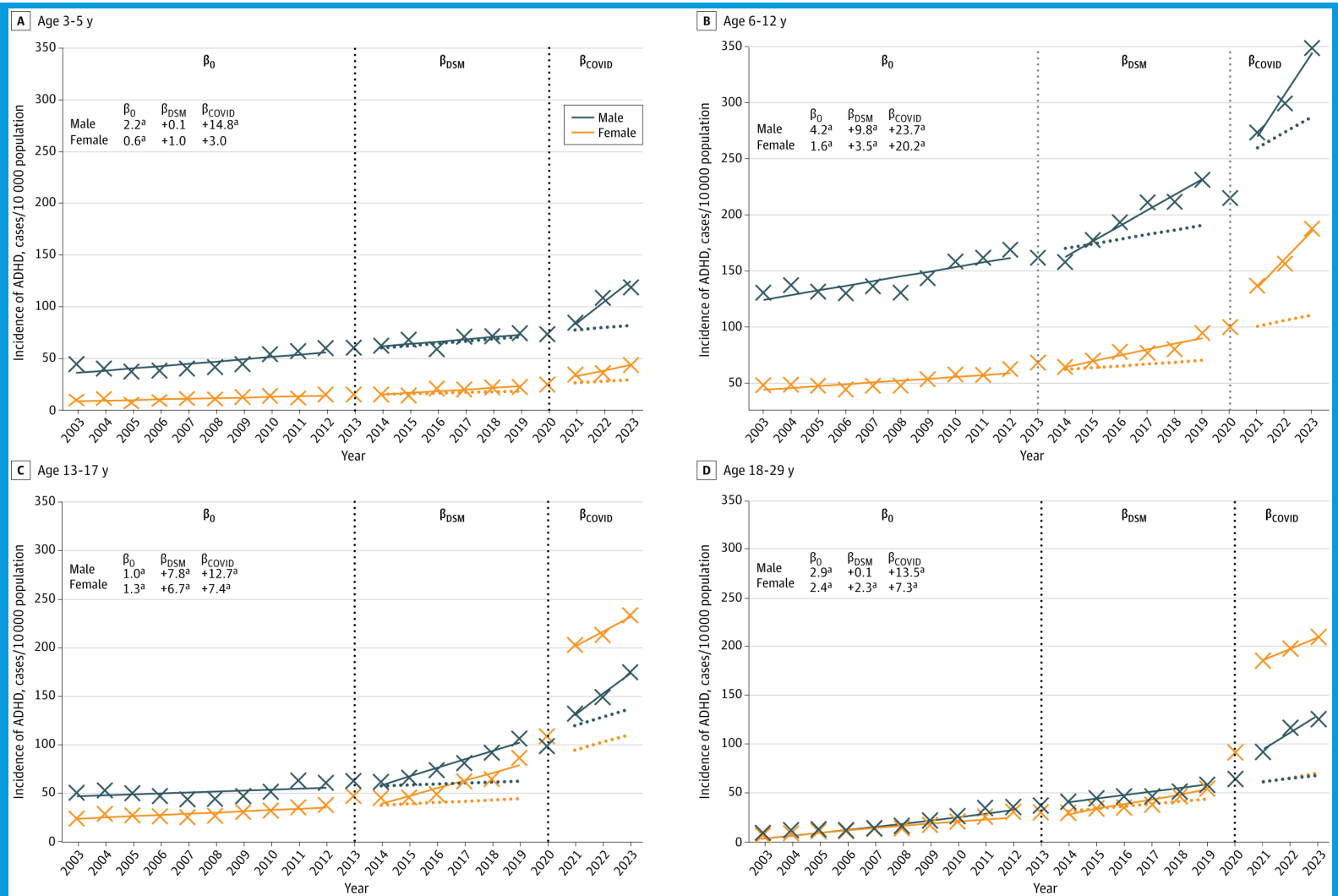
Females more likely to present primarily with inattentive features

INCIDENCE INCREASING

- From 2021 to 2024, the rate increased by approximately 61% in adults ages 30 to 44 and 64% in those 45 to 64 (Truveta 2024)
- DSM-5 specified criteria for adult ADHD
- Growing number of women and people of color
- Possible reasons - increased awareness among patients/providers, reduced stigma
- Concerns for over-diagnosis or over-prescription of stimulant medications
- Diagnostic disparities in underrepresented populations
- Thoughtful evaluation, accurate diagnoses, and adequate treatment can make big difference.

INCIDENCE INCREASING

Cui et al. *DSM-5* changes, COVID-19, and ADHD diagnosis rates in individuals younger than 30 years. *JAMA Network Open*. 2026;9(4):e265775.



RISK FACTORS

- Increased risk of suicide attempt
- Poor job stability and vocational achievement
- Elevated interpersonal conflicts
- Increased risk of substance use disorders and incarceration
- Higher risk for incurring trauma and developing PTSD
- Traffic accidents and violations more frequent
- Overall higher mortality rate – largely accidents and injuries
- Higher rates diabetes, obesity, hypertension

DIAGNOSIS – GENERAL PRINCIPLES

Diagnosis based on clinical interview

No specific testing or biologic markers

Adult recall is unreliable – beneficial to obtain ancillary information

School records, pediatric medical records, collateral reports

If symptoms occur after age 13, more likely to be another cause (other mental health, medical condition)

ADHD questionnaires – helpful as standardized component of assessment and gathering collateral information

ADULT ADHD - DIAGNOSIS DSM 5

Onset prior to age 12 years old

At least 5 symptoms of inattention, 5 symptoms of hyperactivity/impulsivity, or both

Symptoms are present in 2 or more settings (home, school, work, social)

Clear evidence of significant ongoing functional impairment

Do not occur during course of schizophrenia or another psychotic disorder, and are not better explained by another mental disorder (e.g., mood, anxiety, substance use)

DIAGNOSIS – DSM 5

- **Inattention**
  - Makes careless mistakes when working on boring or difficult tasks
  - Difficulty sustaining attention while working on boring or repetitive tasks
  - Difficulty concentrating on what people say even when spoken to directly
  - Difficulty wrapping-up final details; fails to complete tasks
  - Difficulty with organization and getting tasks in order
  - Avoids or delays tasks requiring sustained mental effort
  - Loses or misplaces personal possessions; difficulty finding things
  - Easily distracted by surrounding activity or noise
  - Forgetful; difficulty remembering appointments or obligations

DIAGNOSIS - DSM-5

- **Hyperactivity/impulsivity**
  - Fidgets or squirms with hands or feet
  - Leaves the seat in meetings or situations where sitting is expected
  - Feels restless or needs to be chronically active
  - Difficulty unwinding, relaxing, or engaging in leisure activities quietly
  - Feels compelled to stay active ("on the go" or "driven by a motor")
  - Talks excessively in social situations
  - Blurts out or finishes sentences of others who are talking
  - Difficulty awaiting turn; has to have demands met immediately
  - Interrupts or intrudes on others when they are busy

ADHD SCREENING – CHILDHOOD/SCHOOL

- Early Life
  - What was your home environment like growing up?
  - What kinds of things did you struggle with or get in trouble for at home as a child?
  - Did you have any developmental, behavioral, or health concerns or interventions in early years prior to going to school?

- Educational History
  - How far did you go in school?
  - What was school like for you?
  - Ask about each phase of schooling (elementary, middle school, high school, college, graduate school)
  - Were your grades any better or worse in particular phases of school?
  - What was homework like for you?
  - Did you get into any behavioral trouble in school? What kind?
  - Did you have any social difficulties in school? What kinds?
  - Did you need any special intervention or support at any time? What kind?
  - What kinds of comments would you get on your report cards, or what would you hear from teachers or classmates about you?

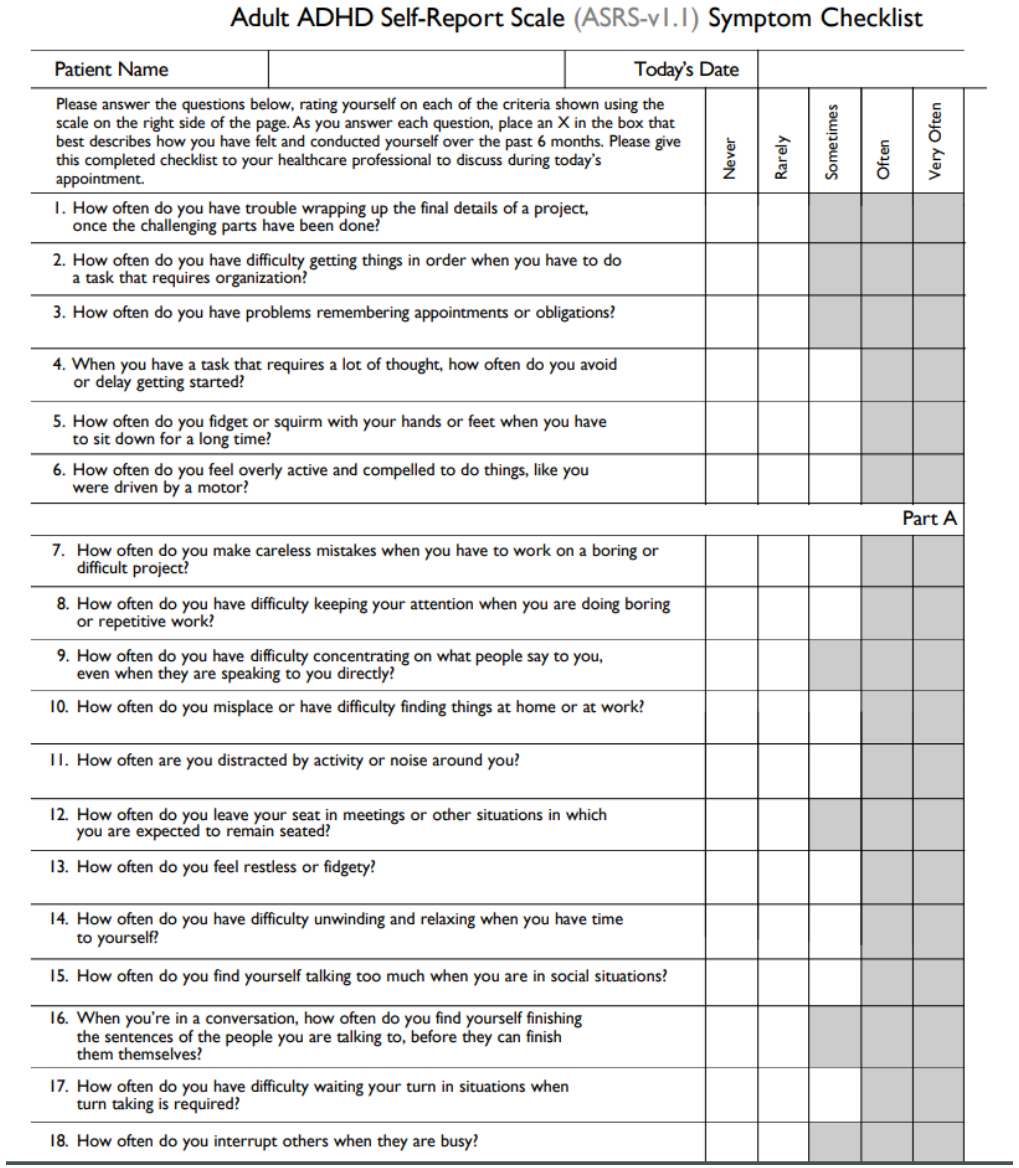
ADHD SCREENING – WORK/HOME

- Occupational History
  - Are you currently employed and if so, doing what?
  - How many jobs have you had?
  - Is there any pattern to why past jobs have ended?
  - What are your strengths at work?
  - What are areas of weakness at work?
  - What kinds of comments would you get in performance reviews, or what would you hear from supervisors or coworkers about you?
  - Have you ever been on a performance improvement plan at work?
- Financial History
  - How do you go about budgeting and paying bills?
  - Any financial difficulties with late payments, overdrafts, debt, bankruptcies, needing financial assistance?
- Driving History
  - How would others describe or rate your driving?
  - How many speeding tickets should you have?
  - Do you have any bumps, dents, or scrapes on your car?

ADHD SCREENING – SOCIAL/HOME

- Relationships
  - Do you have any difficulties in relationships with friends, family, or partners that are related to the reasons you are seeking this evaluation?
  - Any trouble making or keeping friends or romantic relationships?
  - What are your strengths as a parent? What is more difficult for you as a parent?

- Planning and organization
  - How are you with being on time?
  - How do you do with remembering to take things such as badge, keys, lunch, etc. when you need them?
  - What is your approach for managing home to-dos like dishes, laundry, cooking, eating, tidying?
  - How tidy or messy do your spaces tend to be? (e.g. backpack, bag, bedroom, bathroom, desk, office)
  - How do you do with keeping track of your things?
  - How do you go about grocery shopping and cooking?
  - How do you go about packing for a trip?



Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date						
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.			Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?							
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?							
3. How often do you have problems remembering appointments or obligations?							
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?							
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?							
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?							
							Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?							
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?							
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?							
10. How often do you misplace or have difficulty finding things at home or at work?							
11. How often are you distracted by activity or noise around you?							
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?							
13. How often do you feel restless or fidgety?							
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?							
15. How often do you find yourself talking too much when you are in social situations?							
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?							
17. How often do you have difficulty waiting your turn in situations when turn taking is required?							
18. How often do you interrupt others when they are busy?							

QUESTIONNAIRES

- **Wender Utah Rating Scale**
- **Copeland Symptom Checklist**
- **Adult ADHD Self-Report Scale**
- PHQ-9
- GAD-7
- ESS (Epworth Sleepiness Scale)

OTHER CAUSES OF INATTENTION

Condition	Assessment / Treatment
Anxiety disorders	GAD-7 Therapy, antidepressants, anxiolytics
Mood disorders	PHQ-9 Therapy, antidepressants
Autism Spectrum Disorder	ADHD prevalence 50-70% Address anxiety/mood, consider meds
Thyroid disorders	TSH Thyroid supplementation
Sleep disorders	Epworth, STOP-Bang Sleep referral, address insomnia
Anemia, vitamin deficiencies	CBC, ferritin/iron, B12, Vit D
Sensory impairments	Vision / hearing tests
Substance use disorders	Assess alcohol, caffeine, cannabis, illicit drug use

DIAGNOSIS – DSM 5

Onset **prior to age 12** years old

At least 5 **symptoms** of inattention, 5 symptoms of hyperactivity/impulsivity, or both

Symptoms are present in **2 or more settings** (home, school, work, social)

Clear evidence of **significant ongoing functional impairment**

Do not occur during course of schizophrenia or another psychotic disorder, and are **not better explained by another** mental disorder (e.g., mood, anxiety, substance use)

Specifiers:

- Combined, predominantly inattentive, predominantly hyperactive/impulsive presentations
- Partial remission (fewer criteria, still impairment)
- Mild, moderate, severe (symptoms and impairment)

TREATMENT PATHWAYS

ADHD - Adult Diagnosis and Management: Practice Resource | WA Clinical Library

- Address comorbidities
  - Medical conditions
  - Mental health conditions
- Non-pharmacologic strategies
  - Self-help
  - Therapy - CBT for ADHD
  - Brain healthy habits
- Medications – dopamine/norepinephrine
  - Stimulants
  - Non-stimulants

TREATMENT – ADDRESS COMORBIDITIES

- Sleep disorders
  - Insomnia, sleep apnea
- Diabetic control
  - Improved glucose regulation
- Substance use – excess use, withdrawal
  - Caffeine
  - Cannabis
  - Alcohol
  - Other
- Mental health conditions
  - Adequately treat depression, anxiety
- Thyroid dysfunction
- Hearing and vision problems

NON-PHARMACOLOGIC TREATMENTS

- Brain friendly habits
  - Eat regularly, balanced diet
  - Good sleep hygiene
  - Minimize substances
  - Exercise (20 min daily)
  - Mindfulness / meditation
  - Take breaks
  - Distraction-free environments
- CBT for ADHD
  - Psychoeducation
  - Cognitive restructuring
  - Coping skills
  - Organization/planning

CBT for ADHD - studies

Safren et al. (2010) "Cognitive behavioral therapy vs relaxation with educational support for medication-treated adults with ADHD and persistent symptoms" JAMA, Aug 25; 304(8): 875-880.

Young et al. "The Efficacy of Cognitive Behavioral Therapy for Adults With ADHD: A Systematic Review and Meta-Analysis of Randomized Controlled Trials." J Atten Disord, 2020 Apr;24(6):875-888

Liu et al. "Effectiveness of cognitive behavioural-based interventions for adults with attention-deficit/hyperactivity disorder extends beyond core symptoms: A meta-analysis of randomized controlled trials." Psychol Psychother, 2023 Sep;96(3):543-559

PATIENT RESOURCES - WEBSITES

- kp.org
- Children and Adults with ADHD
- Attention Deficit Disorder Association
- National Institute of Mental Health (NIMH)
- LD Online
- Learning Disabilities Association of America
- CHADD: http://www.chadd.org/
- www.understood.org
- www.additudemag.com

PATIENT RESOURCES - BOOKS

- *Driven to Distraction* by John Ratey
- *Delivered from Distraction* by Edward Hallowell, John Ratey
- *You Mean I'm Not Lazy, Stupid or Crazy* by Peggy Ramundo
- *Smart but Stuck* by Thomas E Brown, PhD
- *Women with Attention Deficit Disorder: Embrace Your Difference and Transform Your Life* by Sari Solden
- *More attention, Less deficit: Success strategies for adults with ADHD* by Ari Tuckman

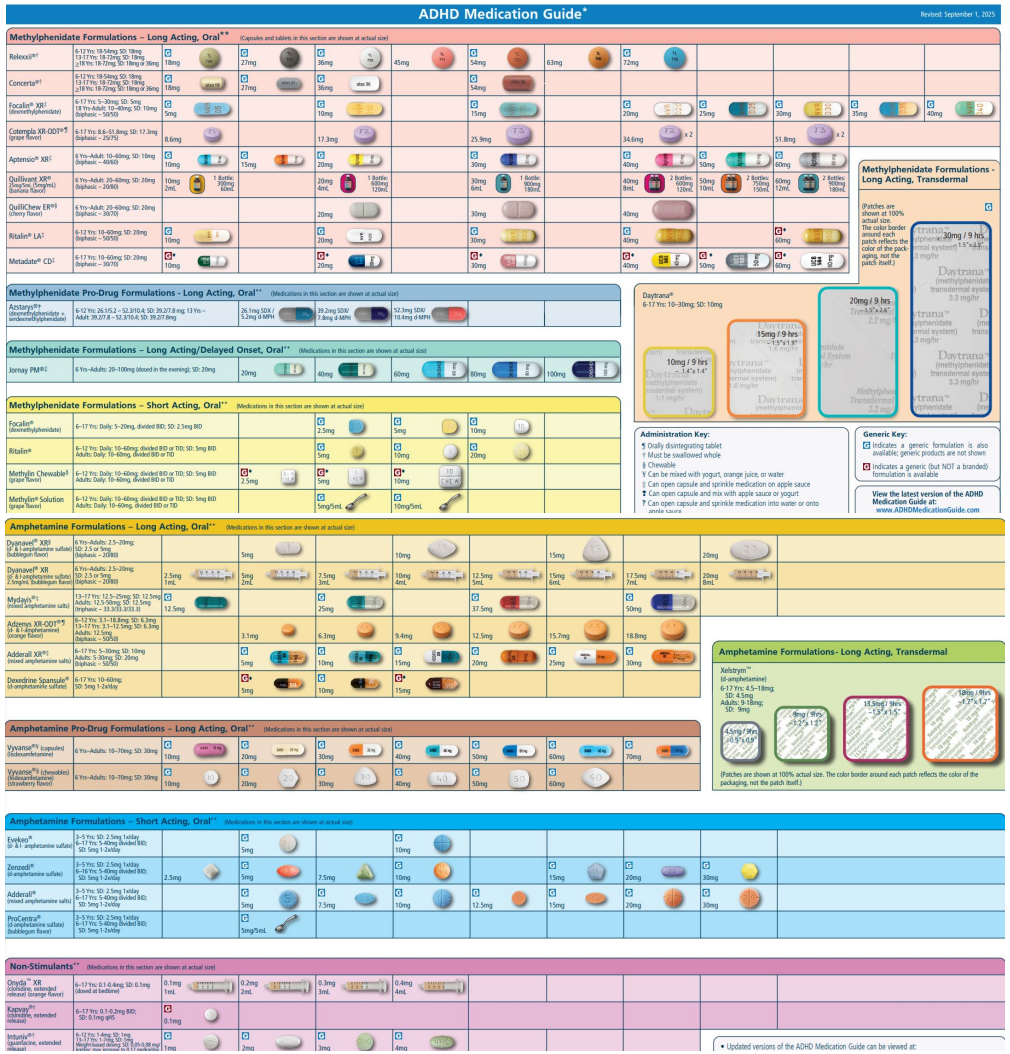
PHARMACOLOGIC TREATMENTS
GENERAL PRINCIPLES

- Both stimulants and non-stimulants effective
  - Patient preference
- Stimulants most effective
  - Addictive potential, 30-day prescription, monitoring expectations
- Consider antidepressants if comorbid anxiety or mood conditions
- Consider non-stimulants if comorbid substance use disorder
- Pregnancy / lactation – risk/risk evaluation
  - Stimulants, antidepressants generally safe
  - Stimulants – coordinate with pediatrician around time of delivery or consider pause in tx
- Cardiac concerns
  - FH sudden cardiac death (risk arrhythmias) – check EKG with stimulants
  - Significant cardiac comorbidity/history – consider non-stimulants

PHARMACOLOGIC TREATMENTS

STIMULANTS

- Effective and well-tolerated
- Immediate and extended-release formulations
- Methylphenidate and amphetamine classes
- Side effects
  - Nausea
  - Tachycardia/HTN
  - Agitation
  - Insomnia
  - Appetite suppression
  - Psychosis
- Tolerance
  - Mixed evidence
  - Holiday, switch classes, use IR +non-stimulant



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STIMULANTS

- Familiarize with couple per class
- Formulary medications - methylphenidate, amphetamine mixed salts or dextroamphetamine
- ADHD Smart RX for pre-built initiation orders
- Example –
  - Start methylphenidate IR – tolerability, effect
  - Switch to XR for longer, smoother coverage (Concerta, Focalin)
  - Side effects / ineffective, switch to amphetamine
  - Start mixed amphetamine salt IR – tolerability, effect
  - Switch to XR for longer coverage
  - Consider patch for poor oral tolerability
  - Lisdexamfetamine if sensitive to onset / crash

PHARMACOLOGIC TREATMENTS
NON-STIMULANTS

Atomoxetine – Strattera (serotonin and NE)	Clonidine – Kapvay (alpha-2 adrenergic agonist)	Guanfacine – Intuniv (alpha-2A adrenergic agonist)	Viloxazine – Quelbree	Buspirone (dopamine and serotonin)
• Up to 4+ weeks to effect • SE - fatigue, nausea, insomnia • Helpful if comorbid anxiety	• Immediate impact • SE – fatigue, orthostatic hypotension • Helpful for sleep, hyperactivity/impulsivity, can dose QHS or BID	• Immediate impact • SE fatigue, LH/dizziness (less than clonidine) • Once daily dosing, helpful for hyperactivity/impulsivity	• Faster than atomoxetine (2 weeks) • SE - fatigue, drowsiness, and headache • 5-HT2 receptor – benefits to anxiety • $$$	• 2-4 weeks to effect • SE – nausea, fatigue, insomnia • Helpful if comorbid anxiety

ANTIDEPRESSANTS

- Viloxazine (Quelbree – SNRI)
  - antidepressant use in Europe
  - ADHD in US
- Not FDA approved but helpful – especially if comorbid anxiety/mood disorder
  - Bupropion
  - SNRI
  - Tricyclics
  - SSRI

TREATMENT – MAINTENANCE

- Recommend patient seen annually for ongoing pharmacotherapy
- Monitoring
  - Comorbid depression / anxiety – PHQ-9 and GAD-2
  - Stimulants – vitals and UDS annually
- UDS – for UDS interpretation, use KPWA Clinical Laboratory Guidance
  - UDS does not currently include methylphenidate; however, direct testing for methylphenidate confirmation is available
  - If cannabis positive, recommend patient cut back and ideally stop, consider quantification
- EKG - no indication for routine monitoring without heart disease or cardiac symptoms
  - Patients with heart disease or cardiac symptoms, carefully balance risk versus benefit
- Address modifiable risk factors (e.g., concomitant use of cannabis, uncontrolled hypertension, uncontrolled anxiety/depression)
- Avoid combining CII stimulants with other controlled substances (e.g., opioids, benzodiazepines, and Z-drugs)
  - Evaluate for deprescribing to reduce polypharmacy and potential risks or side effects

DIAGNOSIS AND TREATMENT – WHEN TO REFER TO MENTAL HEALTH

- Refer to Mental Health for patients with ADHD and complex mental health comorbidities
- Consider E-Consult Psychiatry if:
  - Patient diagnosed externally and questions about accuracy of diagnosis
  - Patient without comorbidities and has failed multiple treatments
- Refer to Mental Health for consultation on diagnosing adult ADHD by choosing the **"medication management" option** in order entry. Please do **not** choose Psychological Testing option
- Please do **not** refer to Mental Health for ADHD assessment without making a concerted effort to obtain prior external records if patient has been previously diagnosed

TAKE HOME POINTS

- Diagnosis is based on clinical interview
  - Childhood onset and functional impairment
  - Family history
  - Collateral and questionnaires
  - Consider other causes and contributing factors
- Treatment
  - Non-pharmacologic strategies
  - Stimulants – develop comfort with couple from each class
  - Non-stimulants
  - Psychiatric complexity – referral to mental health for medication management (not testing)
  - Monitoring – PDMP, VS, UDS

QUESTIONS?


I don't have a short attention span.
You have a short interesting span.
someecards
user card

Psychology Service Line Updates and Adult Autism

Samantha Jimenez, PsyD

Service Line Medical Director, Psychology

Child and Adolescent Psychologist

Philip Ullrich, PhD

Adult Psychologist

E-Consult

Referral Review

Utilization Management

Psychology Service Updates

Objectives

- Cite recent changes to the Psychology Service Line (Adult Psychology Testing)
- Review options for responding to questions about Autism Spectrum Disorder for adults

Psychology Service Updates

Background

Adult Psychology Testing Changes

- Effective April 19, 2026, focus on *Psychology E-consult, pre-surgical assessments*, *select adult cognitive evaluation* (not better addressed by Speech Language and Learning or Neuropsychology), and *complex diagnostic evaluations*

- One adult psychologist, Dr. Phil Ullrich, PhD, 0.7 FTE for adult psychology testing at Northgate

Psychology Service Updates

Adult Psychology Testing Considerations

- All adult psychology referrals will continue to be reviewed by Dr. Ullrich to ensure appropriate triage and support. For patients with lower-severity conditions where treatment can be fully provided within MHW and no additional intervention is needed, referrals may be routed to the EDS.

- When considering a referral for adult Psychology, please follow the adult psychological testing guidelines and submit a Psychology E-consult for review and guidance.

Psychology Service Updates

Referral Guidance

Adult ADHD assessment: Will be supported by Psychiatry. Please refer to Psychiatry rather than Psychology.

Adult Autism evaluation: Adult autism evaluation should not be completed in isolation or as the initial step in mental health care. For patients seeking autism evaluation in the context of ongoing mental health concerns:

- Patients should first discuss their symptoms and care goals with Primary Care.
- Primary Care may initiate treatment and/or refer to Psychiatry or Psychotherapy as appropriate.

Psychology Service Updates

Referral Guidance for Adult Psychology (Cont.)

When adult autism assessment *may* be appropriate:

- Individuals strongly suspected of meeting developmental disability eligibility criteria required by the state to access support services.

- Inform patients that results may be inconclusive without the ability to interview someone who knew them very well during early childhood. If appropriate after discussion, proceed with a Psychology e-consult.

Additional guidance

For more detailed referral support, please refer to the Mental Health & Wellness, Adult Quick Care Guide | WA Clinical Library

Psychology Service Updates

Adult Neuropsychology Services

- There are no current changes to our neuropsychology offerings.
- Adult neuropsychology testing remains available in Tacoma and Capitol Hill.
- Continue to refer to Psychology for neuropsychological testing related to adult cognitive concerns (e.g., dementia or other neurocognitive disorders) when the referral criteria are met.

Additional resources:

- Please refer to the Neurology Quick Care guide for further guidance regarding Dementia/Memory Loss: Neurology Quick Care Guide
- Please refer to the Mental Health and Wellness Adult Quick Care Guide for further guidance regarding Major Neurocognitive Disorder: Mental Health & Wellness, Adult Quick Care Guide | WA Clinical Library: Mental Health & Wellness, Adult Quick Care Guide | WA Clinical Library

Psychology Service Updates

Child Psychology Services

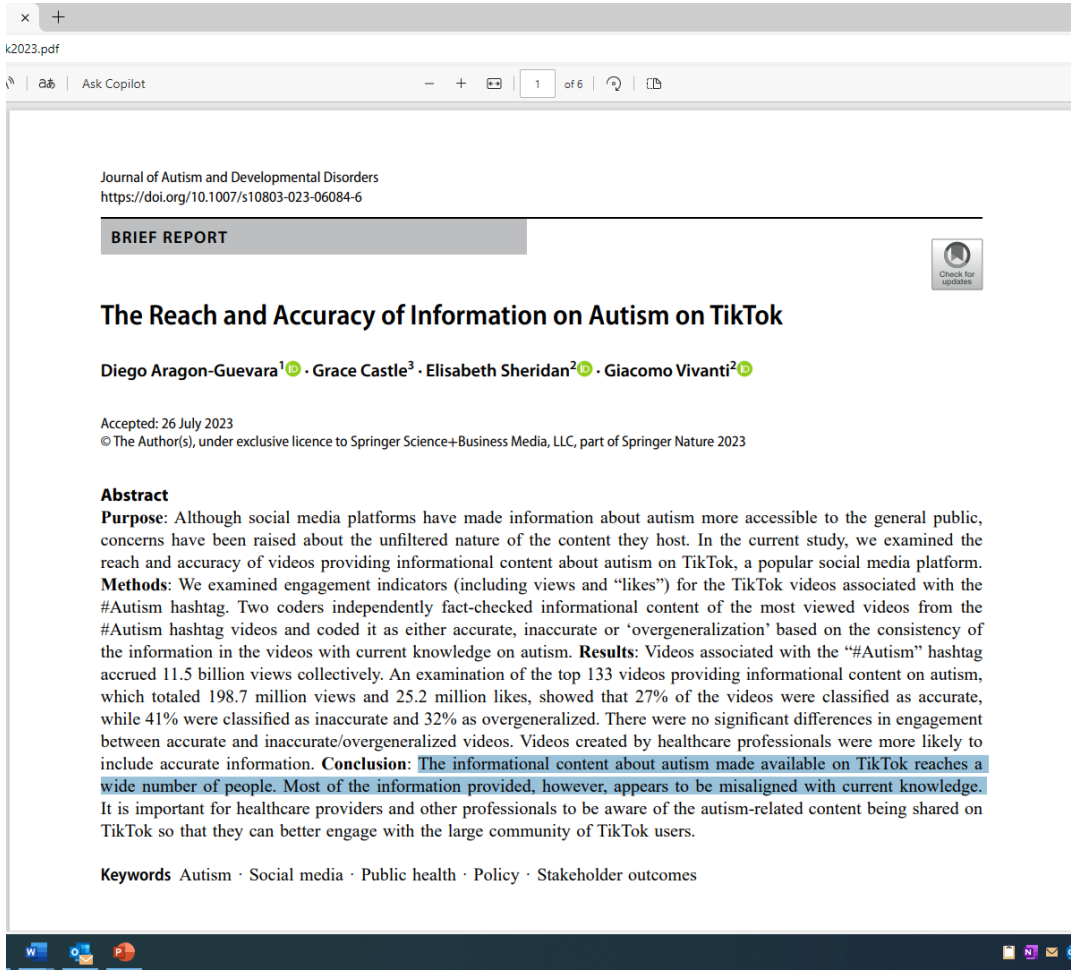
There are no current changes to our child psychology offerings. We will continue to have child psychology services in geographic areas where they are currently offered: Riverfront, Everett, Factoria, Tacoma, and Olympia.

The Question of Autism Spectrum Disorder (ASD) in Adults

Current challenge for Primary Care and Mental Health and Wellness

Popular notions about ASD in our patients' cultures currently are driving healthcare practices

Misinformation



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Ask Copilot 1 of 6

Journal of Autism and Developmental Disorders
https://doi.org/10.1007/s10803-023-06084-6

BRIEF REPORT

The Reach and Accuracy of Information on Autism on TikTok

Diego Aragon-Guevara[1] · Grace Castle[3] · Elisabeth Sheridan[2] · Giacomo Vivanti[2]

Accepted: 26 July 2023

Abstract
Purpose: Although social media platforms have made information about autism more accessible to the general public, concerns have been raised about the unfiltered nature of the content they host. In the current study, we examined the reach and accuracy of videos providing informational content about autism on TikTok, a popular social media platform. **Methods**: We examined engagement indicators (including views and "likes") for the TikTok videos associated with the #Autism hashtag. Two coders independently fact-checked informational content of the most viewed videos from the #Autism hashtag videos and coded it as either accurate, inaccurate or 'overgeneralization' based on the consistency of the information in the videos with current knowledge on autism. **Results**: Videos associated with the "#Autism" hashtag accrued 11.5 billion views collectively. An examination of the top 133 videos providing informational content on autism, which totaled 198.7 million views and 25.2 million likes, showed that 27% of the videos were classified as accurate, while 41% were classified as inaccurate and 32% as overgeneralized. There were no significant differences in engagement between accurate and inaccurate/overgeneralized videos. Videos created by healthcare professionals were more likely to include accurate information. **Conclusion**: The informational content about autism made available on TikTok reaches a wide number of people. Most of the information provided, however, appears to be misaligned with current knowledge. It is important for healthcare providers and other professionals to be aware of the autism-related content being shared on TikTok so that they can better engage with the large community of TikTok users.

Keywords Autism · Social media · Public health · Policy · Stakeholder outcomes

"The informational content about autism made available on TikTok reaches a wide number of people. Most of the information provided, however, appears to be misaligned with current knowledge."

Misinformation

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REVIEW ARTICLE OPEN ACCESS

Quality, reliability and misinformation in mental health and neurodivergence content on social media: a systematic review

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" Misinformation prevalence ranged from 0% to 56.9% and was higher on TikTok than YouTube, and neurodivergence-related content showed higher misinformation prevalence than mental health topics. "

Reduced psychologist workforce

Prior psychological service responses to autism question, and typical results of evaluations

Need to focus on cases of highest acuity

What's wrong with simply doing psychological evaluations for every patient who wonders about autism??

The most common scenario in these evaluations is someone who is chronically depressed or anxious and/or not functioning in life to their satisfaction.

- “Maybe its because I am autistic”
- Has not had a protracted course of psychotherapy
- Failed medication trials but has not consulted with a psychiatrist
- May not have trialed psychotropic medications at all
- Is simply curious, having been exposed to social media and other cultural sources of misinformation

What Patients and Providers Should Know About ASD Evaluation

Evaluation Purpose:

- To determine if a person has Autism Spectrum Disorder using formal diagnostic criteria
  - ASD is a serious developmental disorder marked by significant and broad functional impairments throughout life

- To address a medically necessary question that relates to services and treatment.

What Patients and Providers Should Know About ASD Evaluation

Autism evaluation may be a good fit for:

- Persons with a likely need for community social services (DSHS, DDA, etc) based on inability to function independently in activities of daily living.

- Persons with a clearly documented history of abnormal development, and poor functioning in childhood and adulthood that has never been adequately evaluated.

What Patients and Providers Should Know About ASD Evaluation

Autism evaluation is NOT a good fit for persons who:

- Are independent in basic daily activities
- Have no history of difficulties with independence in basic daily activities
- Have no way of knowing whether or not there were significant problems with developmental and functioning in earliest life (lack of parent collateral).

How to Respond (and NOT respond)

Scenario 1

Patient: “I have been wondering if I am autistic and want to know how I can get tested”

PCP: “Okay, I have placed a referral to **Psychology**”

NOT the recommended response

How to Respond (and NOT respond)

Scenario 2

Patient: “My therapist says I should be tested for autism ….”

PCP: “Okay, I have placed a referral to **Psychology**”

NOT the recommended response

How to Respond (and NOT respond)

Better responses to Scenarios 1 and 2

PCP: “Tell me more about whats going on that led to that question?”

Do they wonder because their mental health problems haven’t responded to treatment?

Simply curious?

Or do we have an initial picture of a lifelong serious developmental disorder?

How to Respond (and NOT respond)

Better responses to Scenarios 1 and 2

Once their experiences and concerns have been reviewed:

Is it best to direct them to mental health care services?

Are they likely to qualify for need for community social services (DSHS, DDA, etc) based on inability to function independently in activities of daily living ?

How to Respond (and NOT respond)

Better responses to Scenarios 1 and 2

Once their experiences and concerns have been reviewed:

Are they likely to qualify for need for community social services (DSHS, DDA, etc) based on inability to function independently in activities of daily living ?

If so, suggest place e-consult to Psychology for review

How to Respond (and NOT respond)

Scenario 3

Patient: “My depression/anxiety hasn’t responded to treatment so I think it might be because I’m autistic….”

PCP: “Okay, I have placed a referral to Mental Health”

NOT the recommended response

How to Respond (and NOT respond)

Better response to Scenarios 3

PCP: “Have you reviewed possible treatment changes with your mental health care providers?”

Are there treatment modalities we can add or change?

E-consult Psychiatry or Psychology ?

How to Respond (and NOT respond)

<u>A viable response to ALL scenarios re: autism in adults:</u>

PCP: “I would like to get input from one of our psychologists about your concerns and see what guidance they might have. I will do this by placing in electronic consult”

Thank you!

Mental Health Resources within Primary Care

Jake Pounds, MD

Associate Medical Director MHW-Eastern WA

Psychiatric Consultant-Mindphone

Psychiatry Consultant-Collaborative Care

Objectives

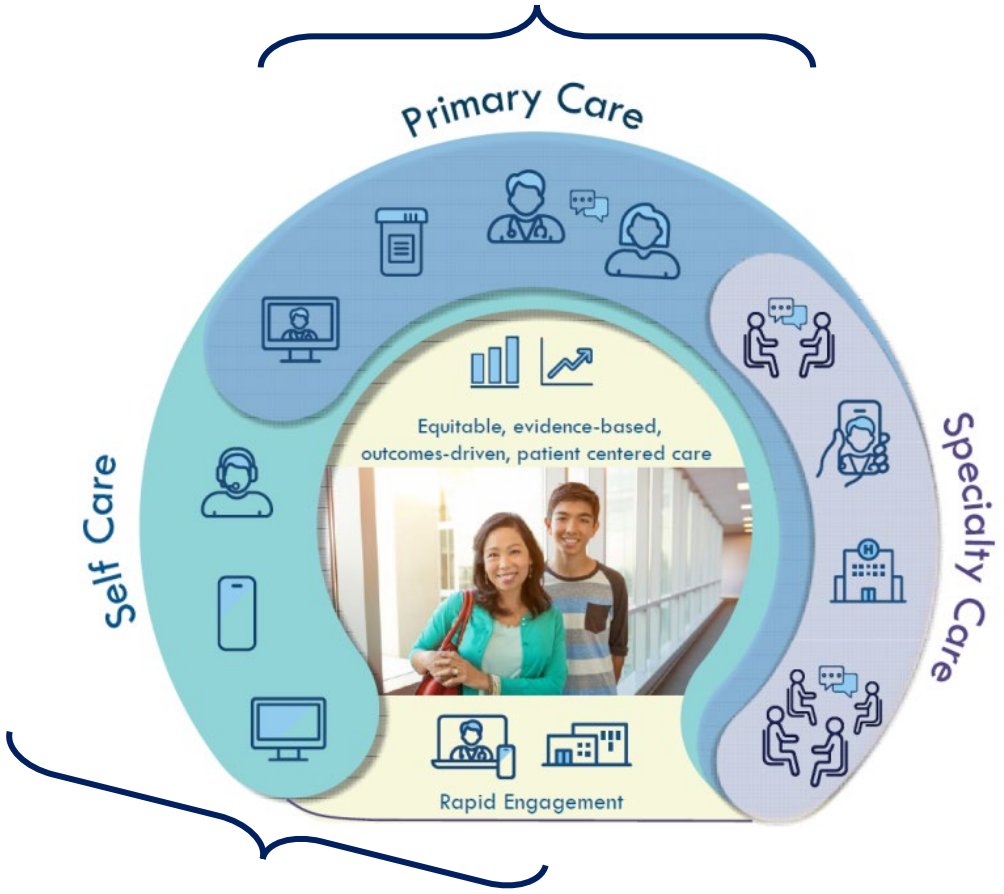
Review Mental Health consultative resources available to KP Clinicians

Identify common mental health conditions that may arise in the Primary Care Setting and reference associated Quick Care Guide to help guide care

Cite the role of the Collaborative Care program in providing high value mental health care for patients within Primary Care

Mental Health Ecosystem

Collaborative Care
Screening & Treatment for hazardous alcohol use
Psychiatry E-Consults



Digital Front Door
Digital Therapeutics

Feedback Informed Care

Case Management Program

Intensive Outpatient Program (future)

Ecosystem Enablers

Workforce & Staffing | **Virtual Care & Technology** | **Data & Analytics**

Network Improvements

Mindphone/Psychiatry E-Consult

Available through Epic Order “E-Consult Psychiatry”

Common Queries:

- -Next step in medication management
- -Diagnostic Clarification
- -Safety concerns/planning

Covered Monday-Friday 8am-5pm with the exception of recognized holidays

- -E-consults placed after hours with be addressed next business day
- -Phone line is **1-888-844-4662**

Mindphone/Psychiatry E-Consult Team

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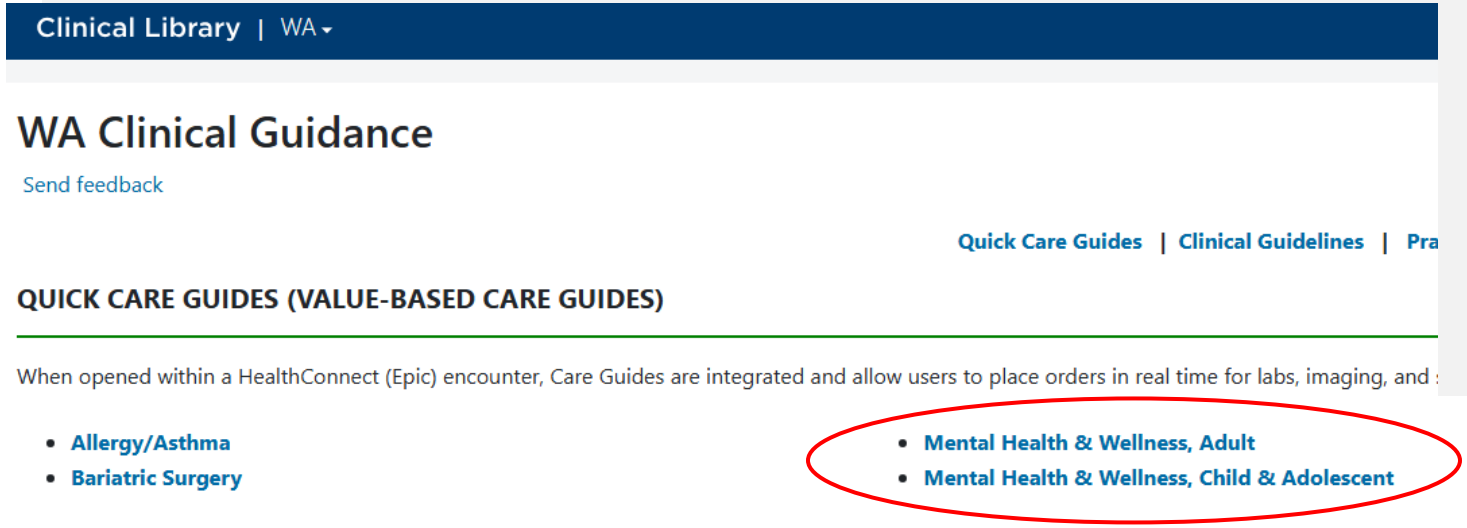
Quick Care Guides

Background

Quick reference for KP Clinicians addressing Mental Health Conditions that may present in Primary Care

Clinical Guidance - KPWA | WA Clinical Library



Quick Care Guides - Adult

- Suicidal Ideation
- Attention Deficit Disorder- Adult
- Autism Spectrum Disorder- Adult
- Bipolar Disorder
- Disordered Eating
- Generalized Anxiety Disorder
- Grief/Bereavement
- Major Depressive Disorder
- Major Neurocognitive Disorder/Dementia
- Obsessive Compulsive Disorder
- Panic Disorder
- Post-Traumatic Stress Disorder (PTSD)

Quick Care Guides-C/A

- Anxiety Disorders
- Attention Deficit Disorder- Child
- Autism Spectrum Disorder- Child
- Disordered Eating
- Gender Care
- Major Depressive Disorder
- Oppositional or Disruptive Behavior
- Substance Use Disorders

Case #1

22 y/o patient presents to their primary care clinic for follow-up appointment. They presented 4 weeks ago with worsening in depression and anxiety symptoms. They were open to medication trial and referral to therapy. Sertraline was started at 25mg daily x 7 days, then 50mg daily. Today they fill out the PHQ prior to the appointment scoring a 24/27 including “3” on Question #9 (Thoughts of self harm or being better off dead).

What is your next step in management?

A. Contact the Crisis Social Worker
B. Increase the Sertraline to 100mg daily
C. Complete the Columbia Suicide Risk Assessment
D. Change the Sertraline to Fluoxetine

Case #1

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Quick Care Guides - Suicidal Ideation

Assessment

PHQ-9 and Columbia Suicide Risk Assessment

Intervention

C-SRA <3: Optimize treatment of MH, consider safety planning

C-SRA ≥3: Warm transfer to MH Crisis Team: **833-378-2774**

Complete MH Crisis Plan (.mhwcrisisresponseplan)

Include family/friend support if possible

Address Risk Factors

Access to lethal means?

Substance Use

Acute Anxiety

Care Coordination

Engagement in Mental Health services

Consider E-Consult Psychiatry

Case #2

31 y/o M presents to primary care physician requesting trial of Adderall for treatment of ADHD. He recently completed an online assessment with a vendor who advertised for ADHD assessments. He reports that he filled out 2 questionnaires and did a brief interview and at the end he was told he had ADHD and the clinician recommended he schedule an appointment with you to start treatment.

What is your next step in management?

A. Start Adderall XR 20mg daily
B. Obtain a Urine Drug Screen
C. E-Consult Psychiatry
D. Referral to MHW Psychiatry

Case #2

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B. Obtain a Urine Drug Screen
C. E-Consult Psychiatry
D. Referral to MHW Psychiatry

Quick Care Guides- Adult ADHD

Neurodevelopmental Disorder consisting of Inattention, Hyperactivity and Impulsivity

-Symptoms must exist in childhood

-Must result in functional impairment

Evaluation and Diagnosis Generally Occur within MHW

-Transferring from outside provider would consider obtaining records

Management and Monitoring

-Stimulant impacts on weight, HR, and BP

-UDS yearly

-Address modifiable risk factors

Can return to Primary Care once stabilized

Quick Care Guides - Autism Spectrum Disorder(ASD)-Adult

Neurodevelopmental disorder displaying difficulties with communication, relationships, flexibility, and sensory sensitivities

-Lifelong impairment and usually dx in childhood

Recent increase in adults pursuing work-up

- Most referred adults do not meet criteria for ASD
- Social discomfort or personality traits ≠ ASD diagnosis

Management and referral Guidance

-ASD itself managed by Mental Health

-Can treat co-morbid conditions (anxiety and depression)

Consider E-Consult Psychology for guidance if questions around process/appropriateness

-Evaluation may be distressing if diagnosis not supported

-Evaluation will require collateral from someone who knew them in childhood

Case #3

27 y/o F presents to primary care with concern for depression. She scores a 20/27 on the PHQ (“0” on Question 9) and reports low mood and other symptoms over the last 6 weeks. She has not tried medications prior to this but does use MJ 3-4x/wk to help with sleep. Asking about family history she reports that both her mother and brother have been diagnosed with bipolar disorder and hospitalized. She denies being hospitalized in the past but does report that she had difficulty sleeping a few months ago with associated difficulties with spending money she did not have and 2 speeding tickets.

What is your next step in management?

A: Diagnose the patient with bipolar disorder and start mood stabilizer

B: Advise patient she does not meet criteria for bipolar yet and start SSRI for depression

C: E-Consult Psychiatry

D: Refer to Mental Health for Assessment

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What is your next step in management:

A: Diagnose the patient with bipolar disorder and start mood stabilizer

B: Advise patient she does not meet criteria for bipolar yet and start SSRI for depression

C: E-Consult Psychiatry

D: Refer to Mental Health for Assessment

Quick Care Guides - Bipolar Disorder

Chronic mental health condition consisting of episodic changes in mood, energy, sleep, and behavior

-Consists of Bipolar 1 (Mania) and Bipolar 2 (Hypomania)

-More likely to present with depression than elevation

Evaluate with clinical interview and questionnaires

-Mood disorders Questionnaire (MDQ)

-Assess for atypical response to prior AD trials

If screens positive and/or high clinical concern:

-Referral MHW Psychiatry

-Consider E-Consult Psychiatry for immediate medication option(s)

Quick Care Guides - Bipolar Disorder

Stable patients can be returned and maintained within Primary Care

-Stable for 6 months

-Can return to MH (or E-Consult Psychiatry) for any acute worsening or medication concerns

Lithium

- BMP, calcium, TSH q6 months
- Lithium level yearly (12-hour trough) or with any dosing change

Valproate

- CBC, AST/ALT q6 months
- Serum level yearly (12-hour trough)

Lamotrigine

- No regular laboratory monitoring
- Be aware of OCP interaction

Atypical Antipsychotics

- Weight q6-12 months
- HgbA1c and Lipid Panel q12 months

Transition of Services Post-IMH

Collaborative Care

- Patients currently seen by IMH will be treated under the Collaborative Care model
- Team based care including PCP, Collaborative Care Clinician, Psychiatric Consultant
- Treat-to-target, measurement-based care
- Population health approach with registry and outreach
- In all PC clinics; additional capacity
- Mind phone still available for psychiatric consultation

Crisis Team

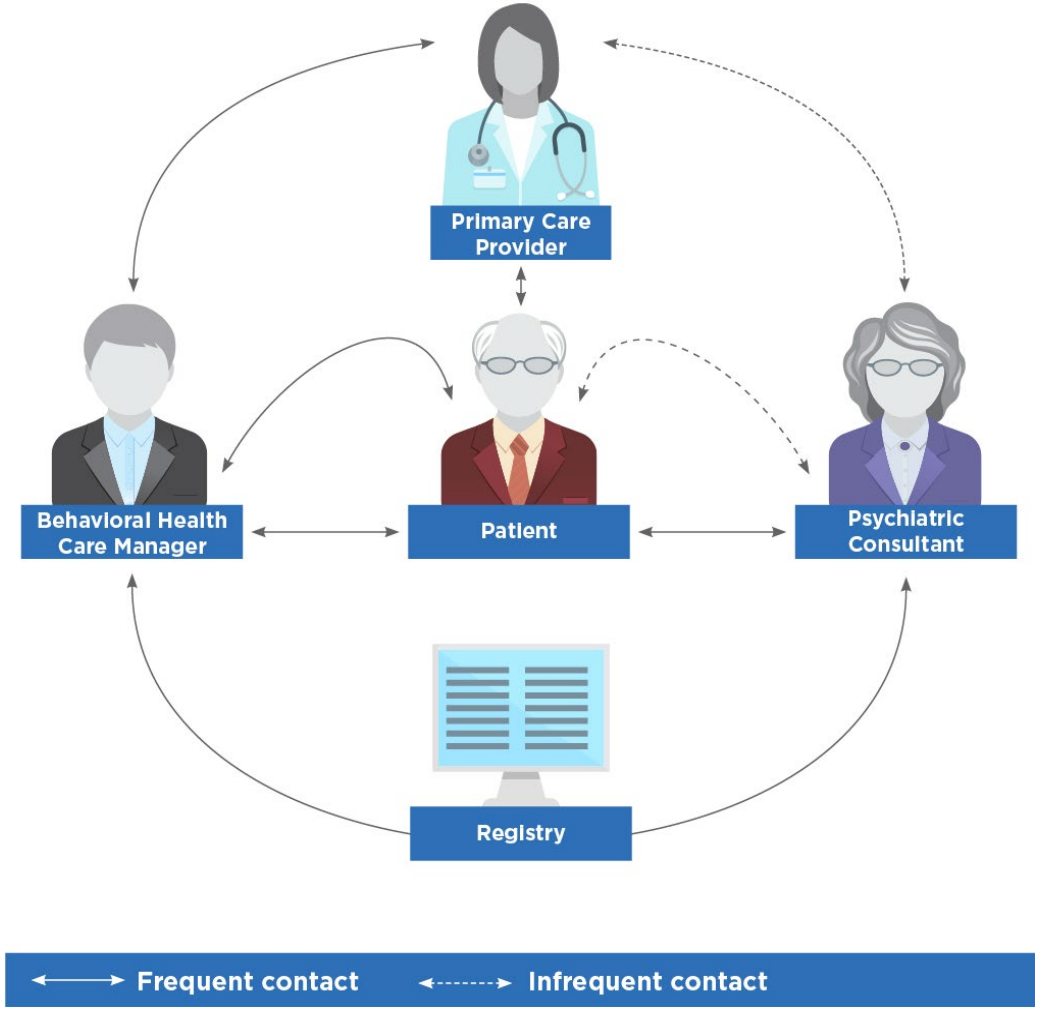
- Dedicated, virtual team available to all **providers** in care delivery who have a patient in crisis
- Phone and video visits available
- Target population Is patients at risk of harm to self or others, acute SUD, domestic violence, recent significant trauma / abuse, patients with acute psychiatric crises requiring immediate assessment and management
- Team available 7:30 am – 11 pm M-F and 2 pm – 11 pm weekends

Urgent Care

- Mental health and SUD assessments, triaging and safety planning in urgent care
- Liaise with DCR, hospital liaison and urgent care teams; coordinate admissions as needed
- OLY and SIL = 10 am – 8:30 pm 7 days a week
  BVU/TSC = 7 am – 12:30 am 7 days a week
  CHN = 24/7

Collaborative Care (CoCM)

- Team of professionals with complementary skills working together to care for a population of patients with mental conditions such as depression or anxiety.
- CoCM adds two vital roles to the usual PCP and patient dyad - the care manager and the psychiatric consultant.
- CoCM success relies on each member of the treatment team understanding their role and believing they have the knowledge and skills necessary to fulfill that role.
- At KPWA:
  - CoCM care managers CCC (CoCM Clinicians) who are Masters or Associate level who provide problem-focused therapy.
  - CoCM RNs who mostly support medication management.



Collaborative Care (CoCM)

The core principles of effective integrated behavioral health care includes a patient-centered care team providing evidence-based treatments for a defined population of patients using a measurement-based treat-to-target approach.

Principles of Care	We apply this principle in the care of ...our patients: None	Some	Most/All
1. Patient-Centered Care	☐	☐	☐
Primary care and behavioral health providers collaborate effectively using shared care plans			
2. Population-Based Care	☐	☐	☐
Care team shares a defined group of patients tracked in a registry. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.			
3. Measurement-Based Treatment to Target	☐	☐	☐
Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are adjusted if patients are not improving as expected.			
4. Evidence-Based Care	☐	☐	☐
Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.			
5. Accountable Care	☐	☐	☐
Providers are accountable and reimbursed for quality care and outcomes.			

AIMS CENTER
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Psychiatry & Behavioral Sciences

Why Practice Collaborative Care?

Collaborative care (CoCM) is beneficial to primary care providers (PCPs) and their patients because it offers better medical care, access to psychiatry experts, helps with challenging patient cases, and team collaboration.

1. **Established Evidence Base**
   CoCM has a robust evidence base of over 80 randomized controlled trials and has been shown to be the best approach to treating depression in many populations and settings.

   CoCM has a strong and expanding evidence base for its use with diverse behavioral health diagnoses such as anxiety, posttraumatic stress disorder, chronic pain, and dementia.

2. **Better Medical Outcomes**
   CoCM is linked to better medical outcomes for patients with diabetes, cardiovascular disease, cancer, and chronic arthritis.

   CoCM is recommended as a primary prevention strategy for cardiovascular events in patients without preexisting heart disease (*Psychosomatic Medicine*, 2014).

3. **Help with Challenging Patient Cases**
   Many challenging cases likely have patients with untreated or undertreated behavioral health conditions. Behavioral health providers do the follow-up and intervention tasks that a busy PCP doesn't have time to do, but make a big difference for patients.

   PCPs are generally more satisfied working within an integrated behavioral health care program than within usual care (*Family Community Health*, 2015).

4. **Faster Improvement**
   A 2016 retrospective study at Mayo Clinic found that the time to depression remission was 86 days in a CoCM program while in usual care it was 614 days.

   Analysis of a large CoCM implementation found that early, intense intervention by the behavioral health provider was key to early improvement in patients with depression symptoms (*Psychiatric Services*, 2015).

5. **It Takes a Team**
   CoCM uses an enhanced care team to provide a population based, treat-to-target approach to care. Through shared care planning, the team makes proactive changes in treatment to make sure that no patients fall through the cracks.

   Only 30-50% of patients have a full response to the first treatment. That means 50-70% of patients need at least one treatment adjustment. Additional experts can help.

Collaborative Care (CoCM)

CoCM Entry Points

- Referral directly from Primary Care
- Self-referred patients via MH Access with low severity/acuity
- Patients who meet inclusion criteria - identified via the CoCM registry (Compass Rose)

Collaborative Care (CoCM)

CoCM Registry Criteria

	Metric Category
Inclusion	
1.	Age 13 and older
2.	**Either** Last PHQ9 Score > 9 and within past 6 months **OR** Last GAD2 Score 3 or greater and within past 6 months
3.	Paneled with a KPWA PCP
Exclusion	
4.	Patient has had a Specialty Mental Health Visit in the past 12 months
5.	Active Hospice Dx on Problem List
6.	Active Dementia Dx on Problem List
7.	Active Psychosis Dx on Problem List
8.	Active Traumatic Brain Injury on Problem List
9.	Active Bipolar Disorder Dx on Problem List
10.	patients Currently Enrolled in SNF
11.	CSRA > 2 in past 18 months (584 days)
12.	Active Personality Disorder Dx on Problem List

Collaborative Care (CoCM)-Benefits for Primary Care

Patients report satisfaction in the CoCM program overall related to:

- Timely access to therapy
- Psychotropic medication management support
  - Typically < 2 weeks
  - Opportunity for same-day program enrollment

Collaborative Care Clinician/CCC and CoCM RN follow up with patient systematically re:

- Problem-focused therapy
- Psychotropic medication management - CoCM RN can pend med orders/follow up on recommendations.
- SDOH screenings support improved patient engagement in medical care and reduce barriers to closing care gaps.

CoCM Psychiatric Consultants can advise regarding:

- Medication initiation
- Medication adjustments
- Medication augmentation
- Referrals to specialty MH

Case #4

45 yo woman identified for CoCM via registry due to PHQ-9 score of 11/27 and GAD-2 score of 4/6. Patient started on sertraline 25mg by PCP 6 months ago and increased to 50mg 2 months ago due to incomplete improvement. Patient presented at CoCM Case review due to ongoing depression/anxiety with PHQ-9 of 10/27 and GAD-2 of 3/6.

What are next step(s) in management?

1. Further assess sertraline tolerability and therapy approach
2. Recommend increasing sertraline to 100mg
3. Recommend change to escitalopram
4. Refer to Psychiatry for medication management

Case #4

45 yo woman identified for CoCM via registry due to PHQ-9 score of 11/27 and GAD-2 score of 4/6. Patient started on sertraline 25mg by PCP 6 months ago and increased to 50mg 2 months ago due to incomplete improvement. Patient presented at CoCM Case review due to ongoing depression/anxiety with PHQ-9 of 10 and GAD-2 of 3/6.

What are next step(s) in management?

1. Further assess sertraline tolerability and therapy approach
2. Recommend increasing sertraline to 100mg
3. Recommend change to escitalopram
4. Refer to Psychiatry for medication management

Case #5

52 yo man with depression (PHQ-9 = 15/27) referred by PCP to CoCM on escitalopram 10mg daily started 3 weeks prior. AUDIT-C indicates daily alcohol use (4-6 drinks) after work. Patient has history of DUI and other incidents related to alcohol use and is interested in support but not in SUD specific treatment.

Next step(s) in management?

1. Increase escitalopram to 20mg
2. Start Naltrexone
3. Start motivational interviewing and offer Naltrexone
4. Refer to Psychiatry for further care

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4. Refer to Psychiatry for further care

Case #6

32 y/o patient with depression and anxiety has had trials of fluoxetine, escitalopram, and bupropion. They report that each helped temporarily for depression, but not long-term, so discontinued after a few months. Currently they also report intermittent high anxiety with insomnia and completed CoCM assessment last week.

Next step(s) in management?

1. Start sertraline trial given they have not tried this medication
2. CCC/CoCM RN further assess response to prior medications and consider additional differential diagnoses.
3. Refer to psychiatry due to previously failed trials.
4. Start trial of lorazepam for high anxiety and sleep

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Next step(s) in management?

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2. CCC/CoCM RN further assess response to prior medications and consider additional differential diagnoses
3. Refer to psychiatry due to previously failed trials
4. Start trial of lorazepam for high anxiety and sleep

Case #7

38 y/o F identified for CoCM via registry due to PHQ-9 score of 13/27 and GAD-2 score of 4/6. Patient has been on fluoxetine in the past and has recently benefited from sertraline increase to 200mg, but continues to struggle with inattention, poor work performance and inability to organize her life.

Next step(s) in management?

1. Change antidepressant to escitalopram 20mg
2. CCC further assess differential diagnosis and therapy approach
3. Refer to MH specialty for further assessment
4. Schedule patient for 1x consultation with Psychiatric Consultant

Case #7

38 y/o F identified for CoCM via registry due to PHQ-9 score of 13/27 and GAD-2 score of 4/6. Patient has been on fluoxetine in the past and has recently benefited from sertraline increase to 200mg, but continues to struggle with inattention, poor work performance and inability to organize her life.

Next step(s) in management?

1. Change antidepressant to escitalopram 20mg
2. CCC further assess differential diagnosis and therapy approach
3. Refer to MH specialty for further assessment
4. Schedule patient for 1x consultation with Psychiatric Consultant

Wrap Up

Mental Health Resources Available for Primary Care

Self-Help

- Quick care guides available for 12 Adult and 8 C/A conditions
- Clinical Guidance - KPWA | WA Clinical Library

Email /Phone a Friend

- E-Consult Psychiatry/Mindphone **1-888-844-4662**

Comprehensive Support

- Brief/problem focused therapy
- Psychiatric Consultant Support

Post Traumatic Stress Disorder (PTSD) Assessment and Treatment

Benjamin Balderson, PhD

Greg Simon, MD

May 7, 2026

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Disclosures

- Neither author have any disclosures or conflicts of interest.

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Outline

- Trauma informed care
- What is PTSD?
- Prevalence in Primary Care.
- Care guidance: 5A's
- Evidence Based Psychotherapies
- Evidence Based Pharmacotherapy

Why trauma informed care in Primary Care

- Trauma is more common than many people realize
- Often unspoken
- Influences mental and physical health
- Primary care sees the results of trauma
- Primary care can be the start for recognition and care
- Trauma informed care can help patients and providers
- Past or current adversity may be shaping health, behavior, and engagement

Trauma-Informed Care

- **Prioritize patient control**: choice, consent, and the ability to pause or decline
- **Make care predictable**: explain what will happen before it happens
- **Reduce reactivity in the visit**: pace, tone, and sequencing matter
- **Focus on clinical impact**: how it affects sleep, pain, adherence, and follow-through
- **Avoid re-exposure**: do not ask for trauma narratives unless clinically necessary
- **Coordinate care**: use referrals (behavioral health, social work) when appropriate
- **Check for current safety** and appropriate supports
- **Consistency across staff** is the intervention

CDC ACE implementation guidance; SAMHSA TIC framework

Trauma Informed Care — During the Visit

- Ask permission for touch every time, even routine:
  - "Is it okay if I…?"
- Narrate before you act:
  - "I'm going to listen to your lungs now."
- Track signs of overload: silence, fast speech, scanning, freezing
  - If present: slow down, name it simply: "We can take this one step at a time."
- Offer choice wherever possible:
  - sequence ("talk first or exam first?")
  - positioning ("sit or lie down?")
- Keep instructions simple and one at a time.

Trauma Informed Care — Opening the Door (Without Forcing Disclosure)

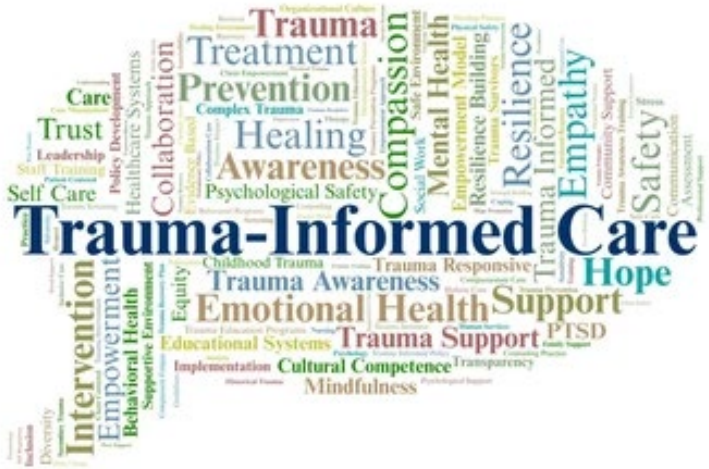
- Ask permission before the topic:
  - "I sometimes ask about stress or difficult experiences because they can affect health. Would it be okay if I ask a couple questions about that?"
  - "We ask all patients about stress and life experiences because they can affect health. You can share as much or as little as you want."
  - "Are there experiences (past or present) that you'd like your care team to be aware of?"
  - "Any preferences about touch, exams, or communication we should know?"
- Keep it present-focused, not investigative:
  - "Is there anything going on right now that's making your health harder to manage?"
- Offer relevance, not curiosity:
  - "Sometimes past experiences show up as sleep issues, pain, or stress responses. If that's part of what's happening, we can take that into account."
- Give an explicit out:
  - "You don't have to share anything you don't want to. We can focus only on what feels useful."
- If they say no: move on cleanly. No pressure, no second ask.

If Trauma or ACE Comes Up

- Acknowledge and express empathy without probing:
  - "That sounds really difficult, and difficult to share. I'm really glad you told me."
- Restrain asking for details about the trauma unless clinically necessary.
- Normalize impact and stay with function:
  - "Such experiences can impact us in a lot of different ways. How is this affecting your sleep / pain / day-to-day right now?"
- Keep them oriented to the present:
  - "Right now, you're here, and we can take this one step at a time."
- Offer choice immediately:
  - "We can keep this at a high level, or we can focus just on your symptoms today."
- Link to care, not catharsis:
  - "We can think about supports or referrals if you want, but there's no rush."

Trauma Informed Care Resources

- KP Learn – 2 hour course
- Center for Health Care Strategies – Trauma Informed Care Implementation Resource Center.
- Trauma Informed Oregon



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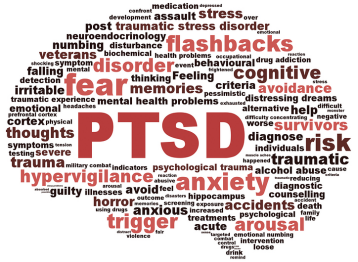
What is PTSD?

- Requires: Person was exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence.
- Response includes
  - RE-EXPERIENCING: Can manifest as intrusive thoughts, nightmares, or flashbacks
  - AVOIDANCE: Actively avoid thoughts, feelings, or external reminders associated with Trauma
  - NEGATIVE CHANGES in thoughts or mood: Persistent negative emotions, feelings of isolation, or exaggerated self-blame.
  - HYPERAROUSAL: Irritability, aggression, risky behaviors, or hypervigilance.
- Symptoms must cause significant distress or functional impairment and not be due to other medical conditions or substance use.
- Lasts more than one month post-trauma.



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PTSD Prevalence

- Not all people who experience trauma develop PTSD.
- Systematic review of 41 studies with over 7 million primary care patients
  - Overall median prevalence in primary care: 12.5% (range 12-39%)
  - Veterans: 24.5%
  - Special Risk Populations (e.g., refugees, immigrants): 12.5%
  - Civilian Population: 11.1%
  - Lifetime prevalence based on diagnostic interviews ranges from 14.5% to 44.3%

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PTSD & Comorbidity

- Post-Traumatic Stress Disorder shows high comorbidity across mental and physical health domains
- Mental health
  - Depression: ~48–55% lifetime prevalence in PTSD
  - Anxiety disorders (GAD, panic): ~30–50%
  - Substance use disorders: ~20–40%
  - Suicide attempts: ~15–25% (≈3–5× general population)
- Physical health
  - Chronic pain conditions (back pain, fibromyalgia, migraines): ~40–60%
  - Sleep disturbance (insomnia, nightmares, fragmented sleep): ~70–90%
  - Cardiovascular disease (HTN, ischemic heart disease): ≈1.5–2× increased risk
  - Gastrointestinal disorders (IBS, functional dyspepsia): ~20–40%
  - Metabolic conditions (obesity, diabetes): ≈1.3–1.5× increased risk
- Utilization / care patterns
  - ≥1 additional chronic condition: ~60–80%
  - ≥2 chronic conditions: ~40–60%
  - Healthcare utilization: ≈1.5–2× higher
  - Medication use: ≈2× higher

Qassem 2021, Flory 2015

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THE 5A's OF PTSD CARE IN PRIMARY CARE

1. ASSESS

- Screen for PTSD in high-risk patients
- Use validated tools (e.g., PCL-5)
- Assess Functioning
- Assess comorbidities (e.g., depression, SUD, pain)

Goal: Identify PTSD and related conditions that impact health.

2. ADVISE

- Educate about PTSD
- Normalize symptoms and reduce stigma
- Discuss evidence-based treatment options
- Offer hope for recovery

Goal: Increase understanding and motivation for care.

3. AGREE

- Collaborate on treatment goals
- Develop a personalized treatment plan
- Clarify expectations and timeline

Goal: Align on goals and plan care that fits the patient's needs.

4. ASSIST

- Provide education and symptom management
- Provide or refer for evidence-based therapies (e.g., CPT, PE)
- Consider medications (SSRI/SNRI) when appropriate

Goal: Provide effective treatments and connect to supports.

5. ARRANGE

- Schedule follow-up appointments
- Monitor symptoms, function, and safety
- Coordinate care and refer to specialized services when needed
- Use Motivational Interviewing to assist with engagement in care

Goal: Ensure continuity, monitor progress, and adapt care.

EVIDENCE-BASED, PATIENT-CENTERED CARE FOSTERS RECOVERY, HEALING, AND HOPE

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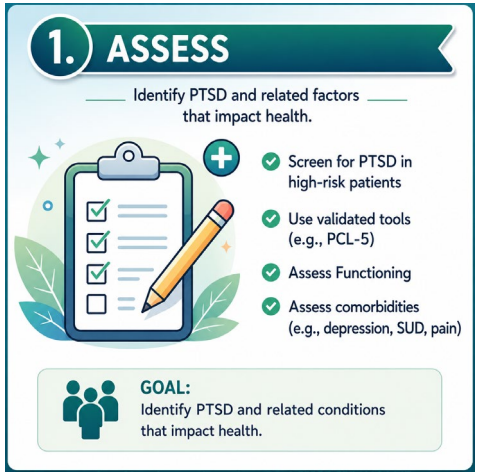
1. Assess: Symptoms

- PTSD Checklist for DSM-5 (PCL-5)
  - Available in EPIC flowsheet. Or online via VA.
  - 20-item screen based on DSM-5 PTSD criteria
  - EPIC will show score in each of the DSM criteria areas and total.
  - Cut-point of 33 used for provisional PTSD diagnosis. Further assess for Dx.
  - Severity can be determined by total score. Range 0-80.



Avoiding memories, thoughts, or feelings related to the stressful experience?	3
Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	2
Met DSM criterion C for PTSD?	Yes
Trouble remembering important parts of the stressful experience?	3
Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wron…	4
Blaming yourself or someone else for the stressful experience or what happened after it?	3
Having strong negative feelings such as fear, horror, anger, guilt, or shame?	4
Loss of interest in activities that you used to enjoy?	4
Feeling distant or cut off from other people?	4
Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	4
Met DSM criterion D for PTSD?	Yes
Irritable behavior, angry outbursts, or acting aggressively?	4
Taking too many risks or doing things that could cause you harm?	1
Being “superalert” or watchful or on guard?	4
Feeling jumpy or easily startled?	4
Having difficulty concentrating?	4
Trouble falling or staying asleep?	3
Met DSM criterion E for PTSD?	Yes
Total score	68

1. Assess: Symptoms (Alternative Measures)

- Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)
  - 5 item yes/no questions
- PTSD Diagnostic Scale (PDS-5)
  - 24-item, cut off score of 28
- Both available online via VA

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1. Assess: Functional Assessment

- When did you first notice symptoms?
- How often do the symptoms occur (times a day, week or month)?
- What changes have you noticed?
  - In your work/school performance?
  - Relationships?
  - Enjoyed/Recreational Activities
  - Physical Activity
  - Use of substances such as caffeine, nicotine, alcohol, marijuana or other substances

Assess Substance Use

- Alcohol use: Use AUDIT-C
- Cannabis use: If more often than weekly, use substance use disorder checklist

Alcohol

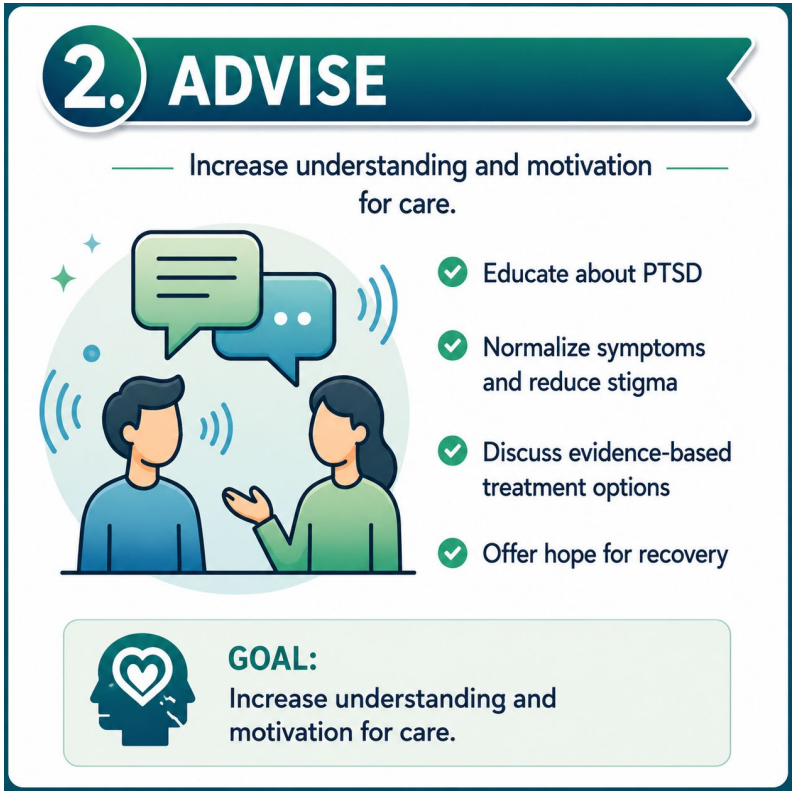
- PTSD often accompanied by unhealthy alcohol use or alcohol use disorder
- Optimal amount of alcohol use is zero, but certainly no more than 1/day and 2/week
- Important to acknowledge perception that alcohol is helpful
  - Short term anxiety reduction is obvious
  - Longer-term anxiety exacerbation is usually not
- Other treatments can still be effective if alcohol use persists – but not as effective
- Alcohol use can undermine behavioral treatments based on desensitization

Cannabis

- Not effective for treatment of PTSD (VA/DoD recommendation “strong against”)
- May contribute to or worsen anxiety in some people
- Cannabis use disorder can coexist with PTSD, and should be addressed

2. ADVISE: Review options for care

- Primary Care
  - Psychoeducation & Symptom Management
  - Brief Therapy
- Specialty Mental Health Treatment
- Medications
- Discuss patient preference, barriers, and facilitators to care.
- VA provides a PTSD Decision Aid to assist patients in reviewing options.
  - https://www.ptsd.va.gov/apps/Decisionaid



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3. AGREE

Align on goals and plan care that fits the patient's needs.

- Collaborate on treatment goals
- Develop a personalized treatment plan
- Clarify expectations and timeline

GOAL:
Align on goals and plan care that fits the patient's needs.

4. ASSIST: PC Psychoeducation and Symptom Management

More suitable when combined with other care options or symptoms more mild.

Patient Education

- Deeper understanding of symptoms can lead to self-care or engaging in care
- Educational handouts from VA. https://www.ptsd.va.gov/index.asp

Relaxation Training

- Help reduce psychophysiological arousal associated with PTSD
- Deep (diaphragmatic) breathing
- Progressive Muscle Relaxation

Behavioral Activation

- Target comorbid depressive symptoms and may also reduce avoidance behaviors

Sleep Management.

- Targeting behavioral and lifestyle changes that contribute to disturbed sleep
- CBT for Insomnia. Individual or group therapy (Mental Health and Wellness)

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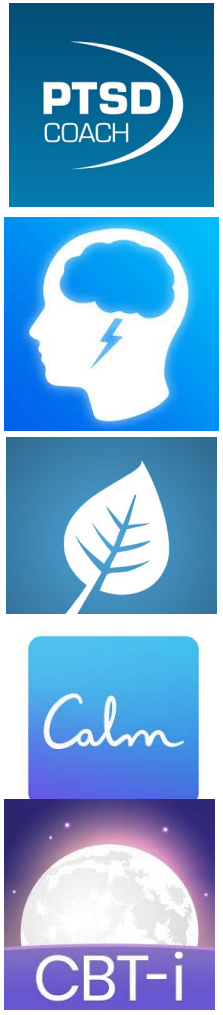
4. ASSIST: Psychoeducation and Symptom Management. Apps



- PTSD Coach. Helps patients learn and cope with symptoms related to PTSD
- Messy Memories. Emotional processing approach to help with difficult/stuck memories
- Mindfulness Coach. Grounding in the present moment can help patients cope better with unpleasant thoughts and emotions
- Calm. Relaxation techniques. Free for KPWA members .infocalm
- CBT-I Coach. Cognitive Behavioral for Insomnia.

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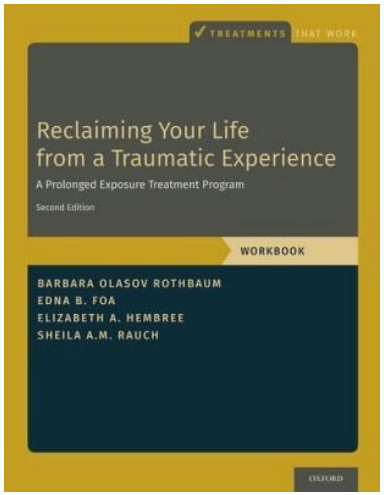
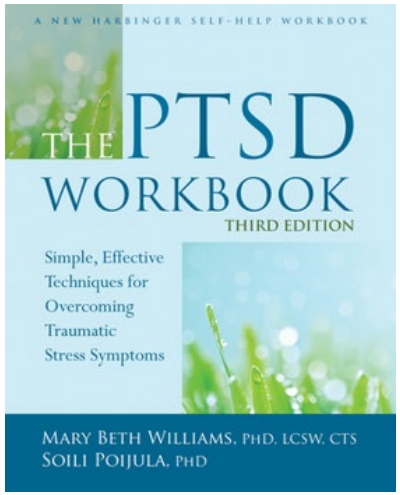
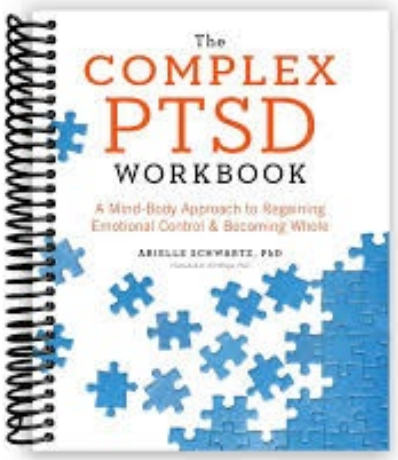
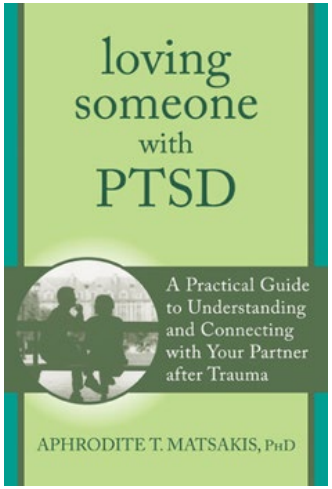
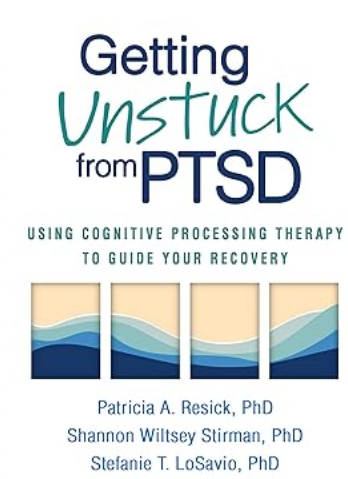
4. ASSIST: Psychoeducation and Symptom Management Books

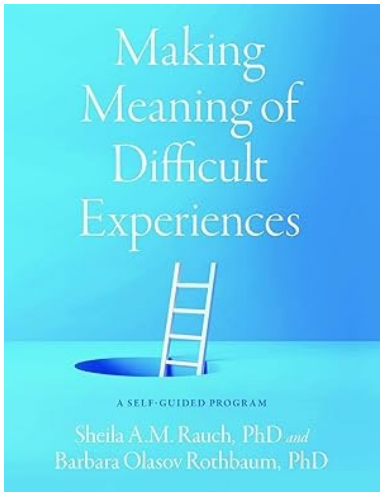


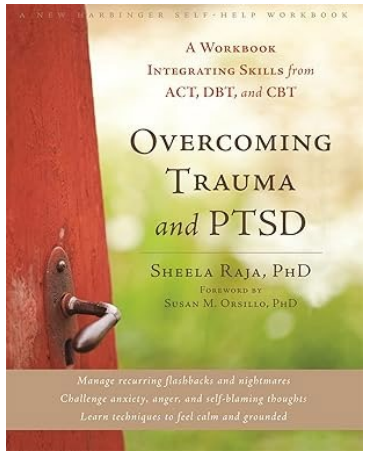












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4. ASSIST: Brief Therapies in PC

- Collaborative Care Management of PTSD in Primary Care
  - Centralized care facilitators to monitor treatment progress
  - Health informatics systems to track sxs and support clinical decisions
  - Integrated Enhanced Mental Health Specialist
  - VA Collaborative Care Model
  - Centrally Assisted Collaborative Telecare (CACT)
    - Web-based and telehealth psychosocial treatment options
  - University of Washington AIMS Center
    - Provides guidance for implementing Collaborative Care
    - http://aims.uw.edu
- Processing Emotions in Primary Care (PE-PC). 4 30-minute session PE.
- Written Exposure Therapy (WET). 5 60-minute sessions PE/CPT

4. Assist Refer to Mental Health & Wellness

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Evidence Based Psychotherapies: First Line Treatments

- **Cognitive Processing Therapy (CPT)**
  - Identify trauma "stuck points" (e.g., self-blame, shame) and, through cognitive restructuring, help the patient have a more accurate, balanced interpretation.
  - 12 60-minute sessions. Studies have varied, with outcomes showing a preference for patient outcomes based on treatment termination.
- **Prolonged Exposure (PE)**
  - Gradually approach trauma-related memories, feelings, and situations that patients has been avoiding since their trauma.
  - 8-15 sessions, typically weekly, 60-90 minutes
- **Eye Movement Desensitization & Reprocessing (EMDR)**
  - Involves calling the trauma to mind while paying attention to a back-and-forth movement or sound (such as a finger moving side to side, a light, or a tone).
  - 12 sessions, typically weekly, 50-90 minutes

- 57 of 100 people who do CPT, PE, or EMDR have meaningful symptom improvement within 3 months compared to 8 out of 100 with no treatment.
- First-line treatment in all major PTSD treatment guidelines, including the American Psychological Association (APA), the International Society for Traumatic Stress Studies (ISTSS), the United Kingdom's National Institute for Health and Care Excellence (NICE), the U.S. Department of Veterans Affairs and Department of Defense (VA/DoD; 20), and the Australian Guidelines. Except APA gave EMDR a conditional rating.

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Evidence Based Psychotherapies: Second Line Tx

- **Written Exposure Therapy**
  - Trauma-focused therapy that guides patient through writing about the trauma and their feelings about it.
  - 32 of 100 people who do WET have meaningful symptom improvement within 3 months compared to 8 out of 100 for with no treatment.

- **Present-Centered Therapy**
  - Non-trauma-focused therapy that helps patient learn how to problem-solve and respond to current life problems related to a trauma.
  - 27 of 100 people who do PCT have meaningful symptom improvement within 3 months compared to 8 out of 100 for with no treatment.

Psychotherapy versus Medications

- The VA/DoD CPG (2023) recommends treating PTSD using individual trauma-focused psychotherapy (specifically CPT, PE, EMDR) over medications based on the current state of the PTSD treatment research.
- Meta-analysis by Merz et al (2019) examined comparative effectiveness studies and concluded there was greater benefit of psychological treatments compared to meds.
- Two prior meta-analyses also showed that trauma-focused psychotherapies lead to greater improvement in PTSD symptoms than medications, and that these improvements last longer.
- Risks for negative side effects or negative reactions are generally greater with medication than with psychotherapy.
- Exception was a recent RCT that compared 1) PE, 2) sertraline and 3) PE + sertraline and found no differences. However, in that study medication management was more extensive than typical medication management.

VA/DOD 2023, Merz 2019, Lee 2016, Watts 2013, Rauch 2021

Meta-analysis of effectiveness of treatments for PTSD

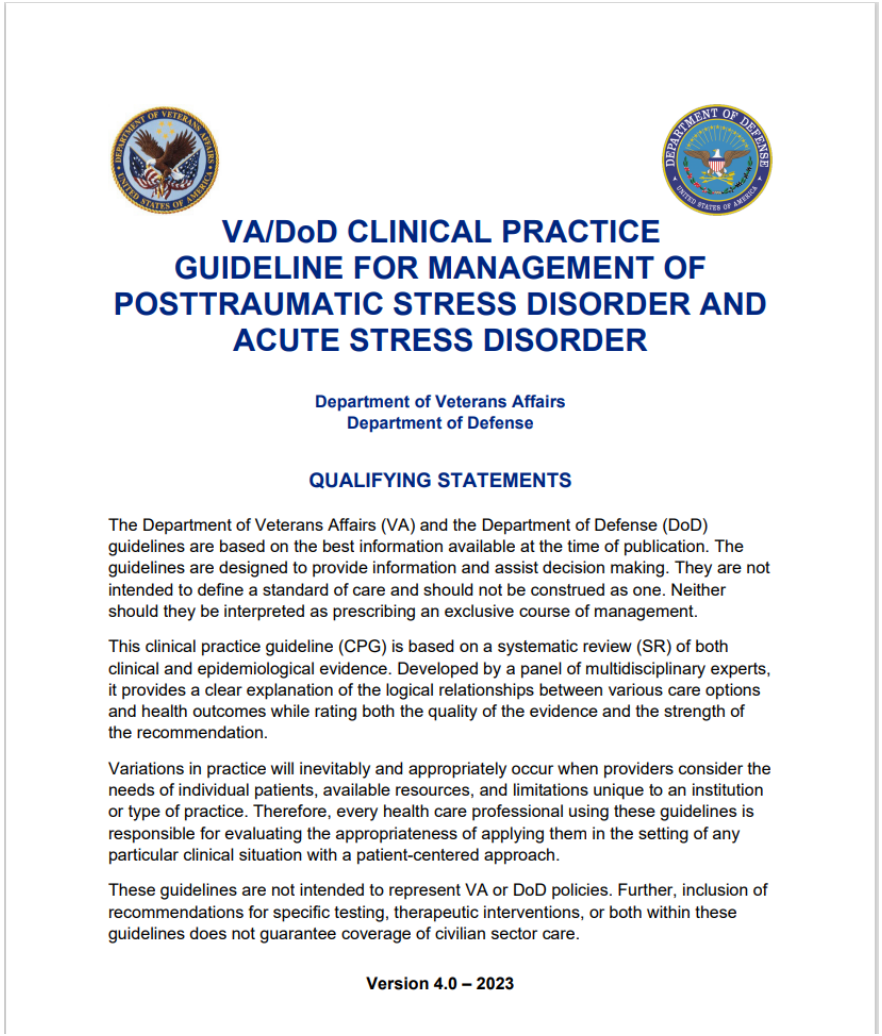
Treatment	G
Cognitive Therapy	1.63
Exposure Therapy	1.08
EMDR	1.01
Paroxetine	0.07
Sertraline	0.41
Fluoxetine	0.43
Risperidone	0.41
Topiramate	1.20
Venlafaxine	0.48

Watts, 2013.

Pharmacotherapy of PTSD - Outline

- First-line treatment with SSRIs/SNRIs
- Second-line or augmentation treatments
- Treatment of nightmares
- Role of benzodiazepines
- Other off-label treatments
- Psychedelic treatments

My trusted source:



VA/DoD CLINICAL PRACTICE GUIDELINE FOR MANAGEMENT OF POSTTRAUMATIC STRESS DISORDER AND ACUTE STRESS DISORDER

Department of Veterans Affairs
Department of Defense

QUALIFYING STATEMENTS

The Department of Veterans Affairs (VA) and the Department of Defense (DoD) guidelines are based on the best information available at the time of publication. The guidelines are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This clinical practice guideline (CPG) is based on a systematic review (SR) of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when providers consider the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Therefore, every health care professional using these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation with a patient-centered approach.

These guidelines are not intended to represent VA or DoD policies. Further, inclusion of recommendations for specific testing, therapeutic interventions, or both within these guidelines does not guarantee coverage of civilian sector care.

Version 4.0 – 2023

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Which SSRI/SNRI

VA/DoD Guideline recommends sertraline, paroxetine or venlafaxine

- No clear difference in average efficacy
- Average tolerability better for sertraline – first choice
- Other antidepressants in VA/DoD guideline
  - Neither for nor against (insufficient evidence): bupropion, citalopram, desvenlafaxine, duloxetine, escitalopram, fluoxetine, mirtazapine
  - Weak against (evidence for ineffectiveness): vortioxetine

Starting SSRIs and SNRIs

- Starting dose for 5 to 7 days
- Secure message or phone check-in (mostly about side effects)
- If no significant side effects at 5-7 days, increase to low end of effective range
- Visit to assess effectiveness after another 3 weeks
- If not sufficiently effective but no significant side effects, increase to moderate dose
- Assess effectiveness after another 3 weeks

Dosing of SSRIs and SNRIs for PTSD

	Starting	Low	Moderate	High
Sertraline	25mg	50mg	100mg	200mg
Paroxetine	10mg	20mg	30mg	40mg
Venlafaxine	37.5mg	75mg	150mg	225mg

Second-line treatment

- If first-line SSRI or SNRI not effective or not tolerated, switch to a recommended alternative
- If two first-line SSRIs or SNRIs not effective, two possible options:
  - Switch to non-recommended SSRI/SNRI (escitalopram, fluoxetine, duloxetine)
  - Augment with second-generation antipsychotic (brexpiprazole, quetiapine, olanzapine)
  - VA/DoD recommendation “neither for nor against”
- VA/DoD guideline recommends “weak against”: risperidone, divalproex, esketamine, vortioxetine

Switching SSRIs/SNRIs

- Usually “cross-taper”, especially when switching away from medication with short half-life (venlafaxine, paroxetine)
- Overlap in 3 or more steps, about a week apart:
  - Sertraline 150mg/day
  - Sertraline 100mg/day and Venlafaxine 37.5mg/day
  - Sertraline 50mg/day and Venlafaxine 75mg/day
  - Venlafaxine112.5mg/day (could increase o 150mg)Duloxetine 60mg/day
- Check in by messaging at each step
- If discontinuation symptoms (tinnitus, dizziness, “brain zaps”), slow down

Prazosin

- Not effective for general treatment of PTSD (VA/DoD guideline “weak against”
- Recommended specifically for treatment of nightmares and sleep disturbance (often in addition to SSRI/SNRI, but rarely alone)
- Dosing:
  - 1mg qhs for 5-7 days (testing for hypotension)
  - Increase to 3mg qhs and check in after 2 weeks
  - May increase to 5mg qhs if inadequate benefit and no adverse effects
- Watch for hypotension (“Do you feel dizzy or faint when you get up at night to go to the bathroom?)

What's the appropriate role of benzodiazepines

- VA/DoD guideline recommends "strong against"
- Usual concerns about tolerance, dependence, and long-term exacerbation of aniety
- Specific concerns about exacerbation of PTSD

Tapering benzodiazepines

- You may not have made this mess, but you still need to deal with it
- Clearly describe risks of long term use (worsening anxiety, hastening cognitive impairment, falls and fractures)
- Offer effective treatment (SSRIs/SNRIs, PTSD-specific psychotherapy)
- Tapering long-term treatment may take 3-6 months
- Set a plan and stick to it (scheduled dose reductions, no early refills)
- Expect that anxiety may increase with each dose reduction, but then improve
- Think of reductions on the proportional scale (smaller in size later on)
- May sometimes need to switch to benzodiazepines allowing smaller dosing increments (clonazepam, diazepam)

Ketamine/Esketamine

- VA/DoD guidelines recommend “weak against” – some evidence for ineffectiveness
- Ketamine-assisted psychotherapy is legal (off-label) and sometimes provided for treatment-resistant anxiety – but not covered by insurance
- Be wary of free-standing (sometimes strip-mall) ketamine clinics
- Could be effective for co-occurring treatment-resistant depression

Psychedelics (Psilocybin, Ibogaine, LSD, Ayahuasca, MDMA)

- VA/DoD guidelines “neither for nor against”
- Generally accompanied by psychotherapy or “guidance” – but that can vary widely
- Psilocybin legalized in Colorado and Oregon (But lots of things that are legal are still not good for you!)
- My view – only in a legitimate clinical trial

Tapering SSRIs and SNRIs

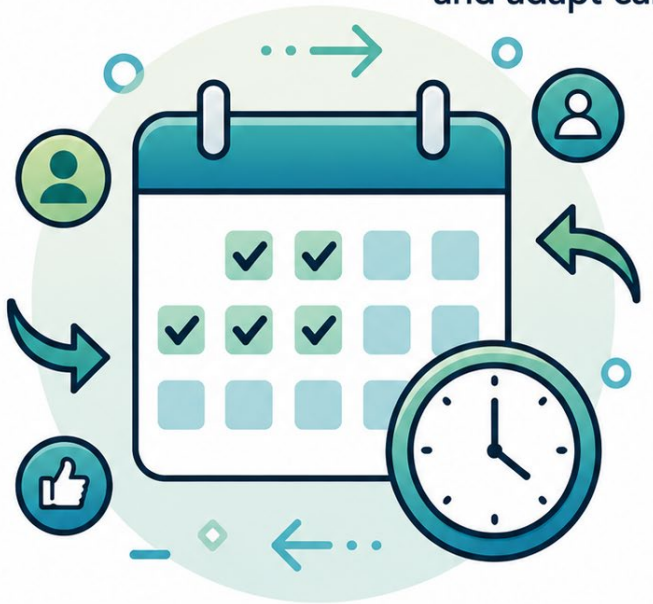
- When
  - Symptoms in remission or minimal for 6 months
  - No major stresses current or anticipated
- How
  - Identify signs of relapse
  - Reduce in 3 or more steps, at least one month apart
  - Check in (could be phone or messaging) before each reduction

SSRI/SNRI discontinuation reactions

- Common, but usually not severe or prolonged
- Most common with shorter half-life (paroxetine, venlafaxine)
- Can be difficult to distinguish from anxiety symptoms
- Before tapering or switching medications, ask “Do you notice problems if you miss a day or two?”
- If severe or prolonged (10-15% of people tapering):
  - Back up and go more slowly
  - Remember about proportional reductions
  - May sometimes need to switch to drug with longer half-life, especially fluoxetine

5. ARRANGE

Ensure continuity, monitor progress, and adapt care.



- Schedule follow-up appointments
- Monitor symptoms, function, and safety
- Coordinate care and refer to specialized services when needed
- Use Motivational Interviewing to assist with engagement in care

GOAL:
Ensure continuity, monitor progress, and adapt care.

Take home points

- Trauma correlated with increased mental and physical health problems and health care use
- Trauma-Informed Care for all
- PTSD present in approximately 12% of primary care pts
- 5A's to help guide care.
- Assess > PCL 5 in EPIC
- Advise > Treatment options: sx management, self-help, Rx, and psychotherapy
  - First line therapies: Prolonged Exposure, Cognitive Processing, and EMDR
  - First-line medications: sertraline, paroxetine, or venlafaxine
- Agree > Agree on what action (if any)
- Assist > Provide resources and referrals
- Arrange > Follow-up

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Questions

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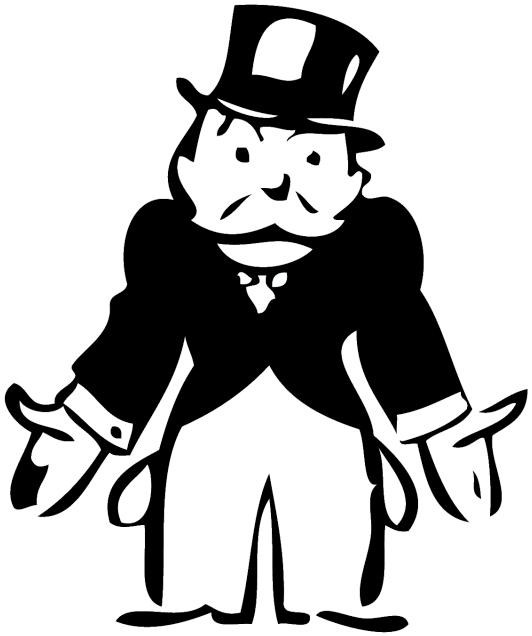
Bipolar disorder maintenance treatment

Stanley Shyn, MD, PhD

Disclosures

No conflicts of interest



In this presentation:

1. Definitions
2. “If it ain’t broke…”
3. Lithium
4. Antiepileptic mood stabilizers
5. Atypicals

By the end of today’s talk, you should be able to:

- Name at least 2 mood stabilizers that **work** for bipolar **depression**
- Name at least 2 mood stabilizers that do not work for bipolar **mania**
- Be able to **match**/identify key **lab monitoring requirements** to key mood stabilizers: lithium, divalproex, and atypical antipsychotics

What is bipolar disorder?

		not impaired	IMPAIRED 
		≥4d	≥1wk or
	depressive episode	**hypomanic episode**	**manic episode**
Bipolar I			≥1
Bipolar II	≥1	≥1	
Cyclothymic disorder	(not quite)	(not quite)	(never)

At least 2y, symptoms present ≥50% of the time
(never symptom-free more than 2 mos)

What is bipolar disorder? (cont'd)

Increased energy (as of DSM-5) **&**

- **Euphoric (+3 more)**
- **Irritable (+4 more)**

Mixed features

Major Depressive Disorder can have depressive episodes with mixed features
Bipolar Disorder can have depressive/hypomanic/manic episodes with mixed features

depressive episode	hypomanic episode	manic episode
	+3 depressive sxs	+3 depressive sxs
+3 hypomanic/manic sxs		

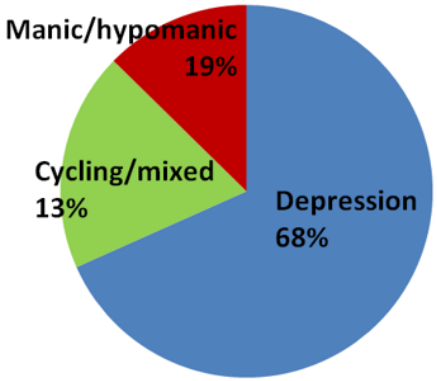
Base episode must meet full criteria; ***mixed*** *specifier* requires 3 opposite-pole symptoms

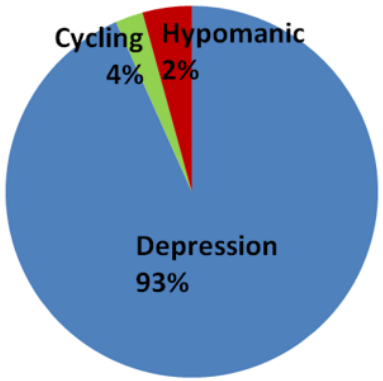
Bipolar is not typically “50/50”…

Why do we miss bipolar?

Most of bipolar disorder is depression.

Bipolar I disorder	Bipolar II disorder
3:1, depressive to manic	**39:1**, depressive to hypomanic





from Judd LL et al, *Arch Gen Psych* 2002, **59**:530
& Judd LL et al, *Arch Gen Psych* 2003, **60**:261

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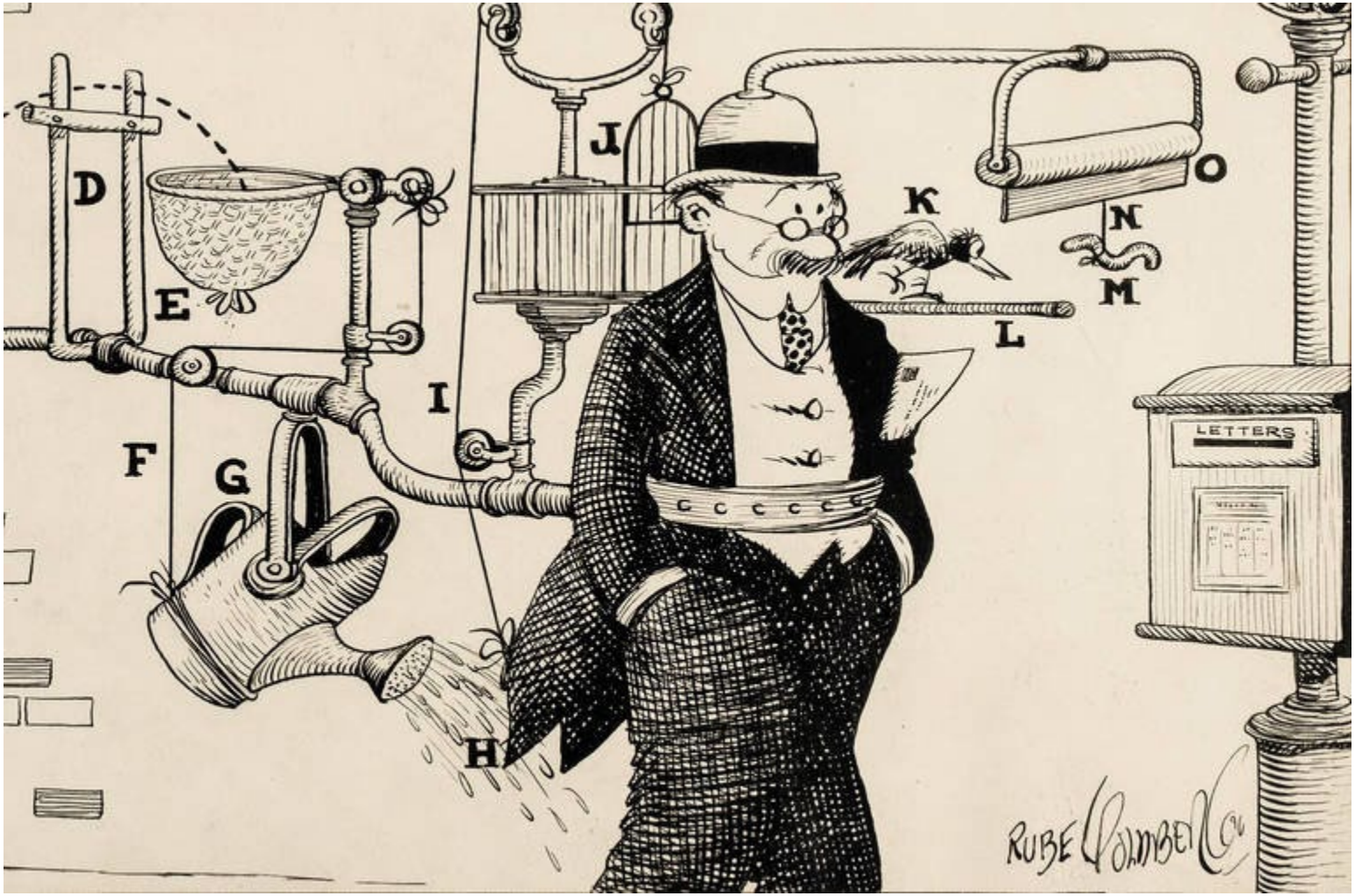
Bipolar *hints*

- Complicated Ddx:
  - Bipolar vs Borderline (counter-transference)
  - Bipolar vs ADHD (episodic vs stable traits)

Mood history	Other Ψ history	Social history
greater recurrence	psychosis (e.g., postpartum psychosis)	frequent changes of city
atypical depressive features (hypersomnia, hyperphagia, leaden paralysis, rejection sensitivity)		…relationship
mood lability		…job
		more legal problems
		…$ problems
		…substance issues
		can be higher utilizer of health care services

If it ain't broke…



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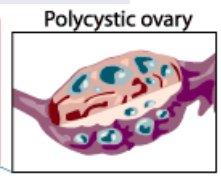
Choosing a mood stabilizer…

Class	Generic name	Trade name	Bipolar mania	Bipolar depression	Bipolar maintenance
	lithium		x		x
anti-epileptics	lamotrigine	LAMICTAL			x
	carbamazepine XR	EQUETRO	x		
	valproate	DEPAKOTE	x		
atypicals	aripiprazole	ABILIFY	x		
	asenapine	SAPHRIS	x		
	cariprazine	VRAYLAR	x	x	
	lumateperone	CAPLYTA		x	
	lurasidone	LATUDA		x	
	olanzapine	ZYPREXA	x		x
	olanzapine-fluoxetine	SYMBYAX		x	
	paliperidone	INVEGA	x		
	quetiapine	SEROQUEL	x	x	(adjunct)
	risperidone	RISPERDAL	x		
	ziprasidone	GEODON	x		



On antidepressants…

	Mood stabilizer + antidepressant (n=179)	Mood stabilizer + placebo (n=187)	P-value
Durable recovery*	23.5%	27.3%	0.40
Tx-emergent affective switch[z]	10.1%	10.7%	0.84

**8 consecutive weeks of euthymia*

[z]*by 16wks or w/o durable recovery (out to 26wks)*

Sachs GS et al, *NEJM* 2007. **356**:17

- **STEP-BD** (Systematic Treatment Enhancement Program for Bipolar Disorder)
  - n ≈ 180 for each group
- **mood stabilizer** = primarily Li^+, VPA, CBZ
- **antidepressant** = paroxetine or bupropion

Case #1

29yo M whose bipolar depression was stabilized on olanzapine-fluoxetine (7.5 mg – 20 mg) 3mos ago and is now sleeping 2h a night and exhibiting restlessness and pressured speech on mental status exam. His girlfriend called the other day to report she is concerned about his stated plan to move to Alaska to start a new fishery business (despite no previous experience). A reasonable next step might be to:

A. **INCREASE the olanzapine portion** of patient's Rx combination to 30 mg HS.

B. STOP **fluoxetine** and consider adding lithium and/or a call to Mind Phone.

C. Add **lamotrigine** 100 mg daily.

D. ADD **risperidone** to olanzapine-fluoxetine.

Lithium maintenance

Class	Generic name	Trade name	Bipolar mania	Bipolar depression	Bipolar maintenance
	lithium		x		x

for lithium	Q6mo
BMP	+
TSH	+
^lithium level (12h)	(+)

^*varies* depending on dose, stability of Li+ levels over time, changes in kidney functioning, & reliability of patient to report changes

With new dose, wait **5d** for steady state.

I like **0.6-0.9** better than 0.6-1.2 for target range. (*But if patient doing well below 0.6, may be better to "treat the patient, not the number."*)

- Effective monotherapy for some patients
- Narrow therapeutic window

- Kidney and thyroid risks
- AVOID concurrent NSAIDs (aspirin, sulindac safer; acetaminophen also okay)

- Anti-suicide benefit

Case #2

54yo F with bipolar disorder is stable on lithium 900 mg QHS (last lithium level was 0.90) and quetiapine 200 mg QHS. She mentions in today's office visit that she will be having R carpal tunnel release surgery in 2wks with Ortho Hand.

Any care coordination that might be helpful here?

AED maintenance

Class	Generic name	Trade name	Bipolar mania	Bipolar depression	Bipolar maintenance
anti-epileptics	lamotrigine	LAMICTAL			x
	carbamazepine XR	EQUETRO	x		
	divalproex	DEPAKOTE	x		

	pre-start HLA-B*1502	CBC Q3-6mo	LFTs Q3-6mo	12h drug level Q6-12mo	notes
⬆ lamotrigine	consider				avoid co-use with estrogen
carbamazepine XR	consider	+	+	4-12	repeat at 4wks (*auto-induction)
⬇ divalproex		+	+	50-125	avoid in young women

* re: **carbamazepine** auto-induction--

--co-use with antipsychotics will often require **upward** antipsychotic dose adjustment

Case #3

40yo M whose bipolar has been stably managed the past 10y with paroxetine 30 mg HS, lithium 600 mg QHS, and carbamazepine 200 mg BID. A recent chem panel shows sodium of 119. Which of this patient's Rxs could be behind his hyponatremia?

A. paroxetine

B. lithium

C. carbamazepine

D. A and B

E. B and C

F. A and C

Antipsychotic maintenance

Class	Generic name	Trade name	Bipolar mania	Bipolar depression	Bipolar maintenance
atypicals	aripiprazole	ABILIFY	x		
	asenapine	SAPHRIS	x		
	cariprazine	VRAYLAR	x	x	
	lumateperone	CAPLYTA		x	
	lurasidone	LATUDA		x	
	olanzapine	ZYPREXA	x		x
	olanzapine-fluoxetine	SYMBYAX		x	
	paliperidone	INVEGA	x		
	quetiapine	SEROQUEL	x	x	(adjunct)
	risperidone	RISPERDAL	x		
	ziprasidone	GEODON	x		

When antipsychotics are **needed** in bipolar:

- acute bipolar **depression**
- **psychotic** symptoms (present or sometimes past)
- **replacement** of a non-antipsychotic required

Side effects to watch:

- extrapyramidal effects
- tardive dyskinesia (2% instead of 20% annual risk)
- galactorrhea (more w/ risperidone, paliperidone)
- metabolic syndrome (sometimes countered with metformin)

More about specific atypicals…

Class	Generic name	Trade name	Bipolar mania	Bipolar depression	Bipolar maintenance
atypicals	quetiapine	SEROQUEL	x	x	(adjunct)

- Quetiapine & lumateperone are the *only two* Rxs FDA-approved for **both** bipolar 1 and bipolar 2 depression
- Very frequently under-dosed (e.g., 25 or 50 mg); benefit for acute bipolar depression established at 300 mg HS in clinical trials
- *SEDATING…*

Class	Generic name	Trade name	Bipolar mania	Bipolar depression	Bipolar maintenance
atypicals	olanzapine	ZYPREXA	x		x
	olanzapine-fluoxetine	SYMBYAX		x	

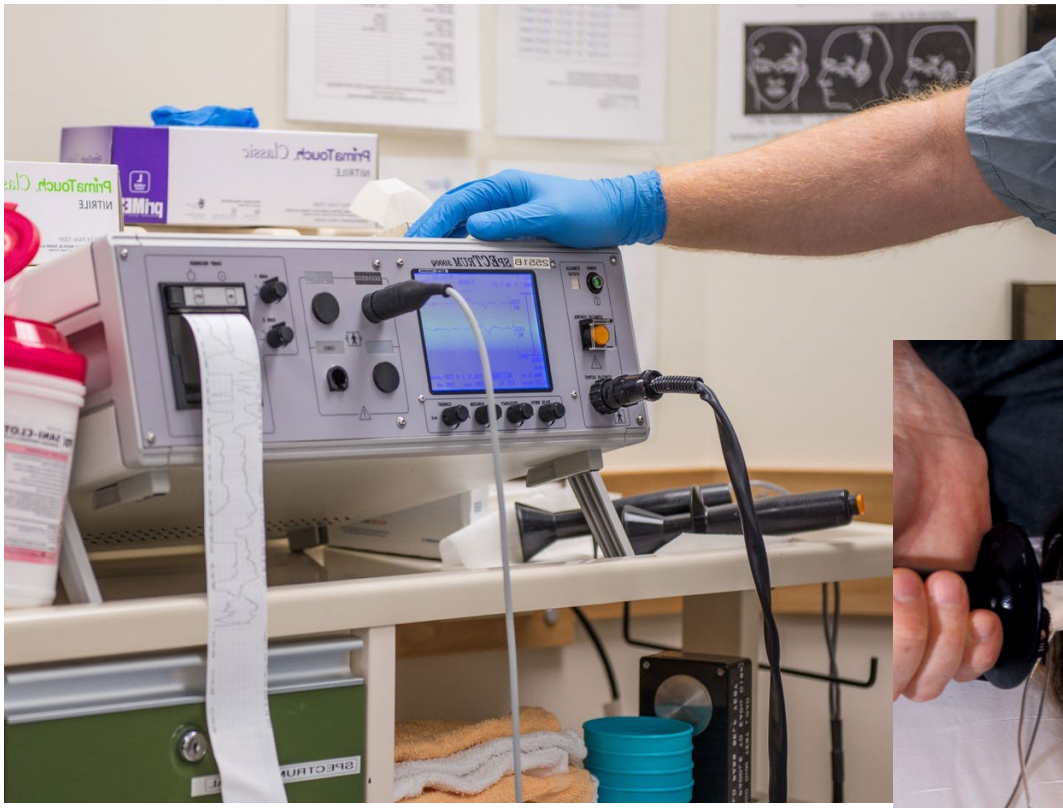
- Officially, SYMBYAX is [6 mg olanzapine – 25 mg fluoxetine] or [12 mg olanzapine – 50 mg fluoxetine], but we will often combine / approximate with separate **generic** ingredients.
- The rare exception where there is an FDA-approved SSRI for use in bipolar disorder…

Lab monitoring

for atypicals	baseline	1mo	2mo	3mo	12mo	quarterly	Q1y	Q5y
weight	+	+	+	+	+	+		
blood pressure	+			+	+		+	
fasting glucose	**+**			**+**	**+**		**(or A1c)**	
lipids	**+**			**+**	**+**		**+**	**+**

ADA and APA guidelines for patients on atypicals
as reviewed in Hasnain M et al, *Primary Care Diabetes*, 2008, **3**:5-15

Electroconvulsive therapy (ECT)



Case #4

19yo F is recently discharged from inpatient psychiatry after an episode of acute mania. Inheriting which of the following Rx plans post-discharge might be a good reason to call Mind Phone? (More than one might be correct.)

A. divalproex + lamotrigine

B. lithium

C. quetiapine

D. lurasidone + lamotrigine

Case #5

39yo euthymic M with a history of bipolar 2 presents to establish care for medication management. His current regimen includes:

bupropion XL 150 mg QAM
venlafaxine XR 225 mg QAM
risperidone 1 mg BID

You could reasonably…

A. Suggest replacing all 3 Rxs above with **quetiapine**.

B. Keep risperidone but suggest replacing bupropion XL and venlafaxine XR with **lithium**.

C. **Refer the patient to MH** for a medication 'tune-up.'

D. Make **no** changes, reassure the patient that you are able to refill all of the above Rxs as written (but provide some psychoeducation).

Summary

- Most of bipolar disorder is depression.

Questions or Comments?

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PERMANENTE MEDICINE®
Washington Permanente Medical Group

Management of Peripartum Mood and Anxiety Disorders (PMAD)

Natalie Wolff, MD

Adult Psychiatry, Olympia

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Learning Objectives

- **Know how to:**
  - Appropriately screen all patients for peripartum mood and anxiety disorders
  - Provide evidence-based care for peripartum depression, anxiety, PTSD, OCD
  - Counsel patients effectively on the risks and benefits of medications
  - Get help for more complex cases

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**mom/mother/maternal- person with gestational capacity*

I Don’t Know What To Do, What Should I Do?

- Google: “UW Perinatal Mental Health Care Guide”: https://perc.psychiatry.uw.edu/perinatal-mental-health-care-guide-6/
- MindPhone
- UW Perinatal Consult Line: https://perc.psychiatry.uw.edu/perinatal-pcl/
- Refer to psychiatry

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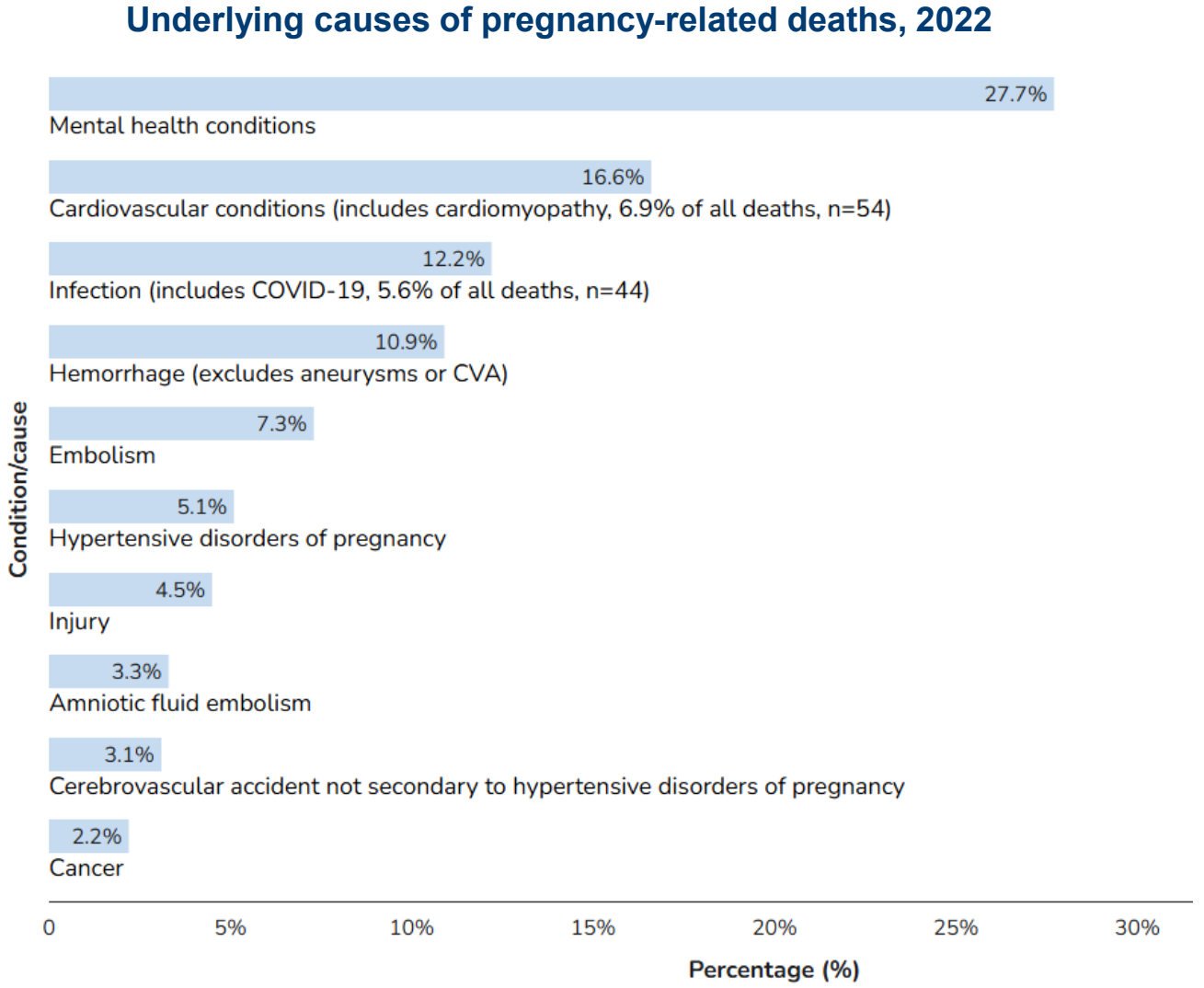
Risks of Untreated PMAD

- Increased impulsivity
- Less attendance of prenatal case
- Increased substance use/misuse
- Poor fetal growth, low birth weight
- Placental abnormalities
- Fetal distress, toxic stress of the newborn
- Pre-eclampsia, pre-term birth
- Impaired attachment and bonding, negative impact on child development
- Chronic illness, death by suicide

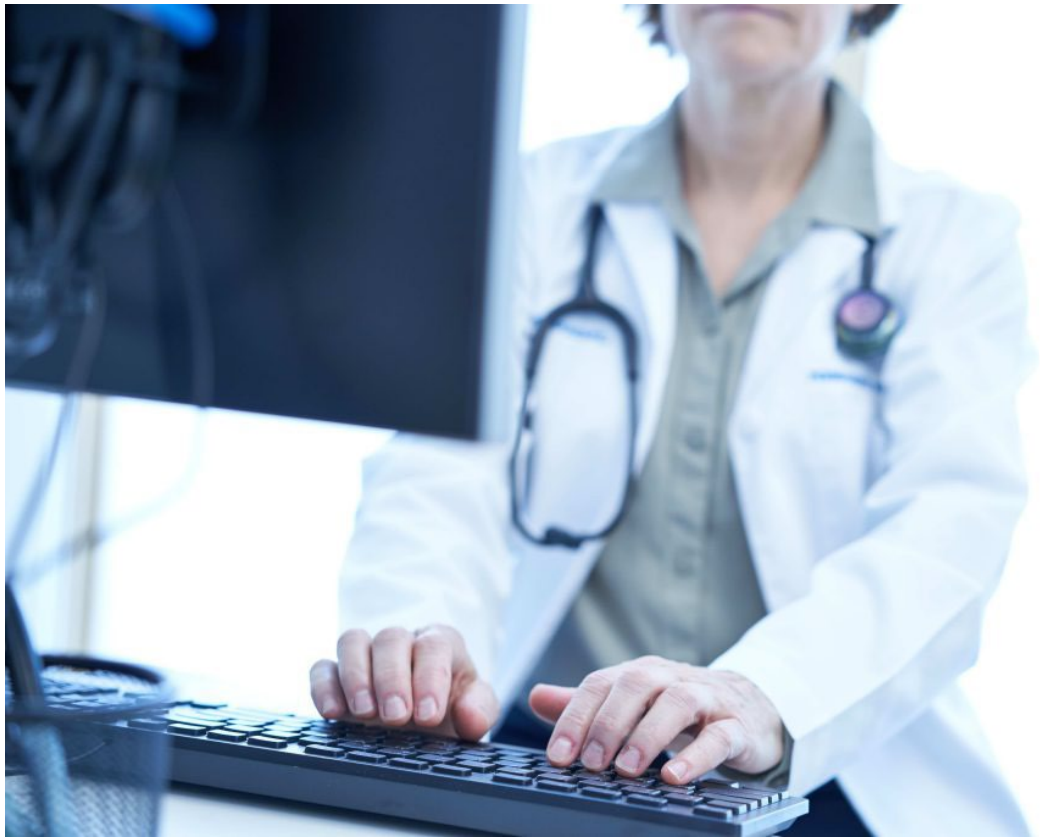


Data from Maternal Mortality Review Committees, 2022.
Stewart et al. Psychiatr Clin North Am. Sep 2023.

Prevention: Prenatal Counseling

"Assume pregnancy is imminent for all female patients between the ages of 8 and 48 years."

- Ask: Are you using any form of birth control?
  - If no: Are you planning a pregnancy?
    - If no: How are you preventing pregnancy?
- No use of highly effective birth control:
  - Patient should start taking a prenatal vitamin
- Remind patients 50% of pregnancies are unplanned, and counsel on risks and benefits of their medications in pregnancy.
  - Encourage stability/supports



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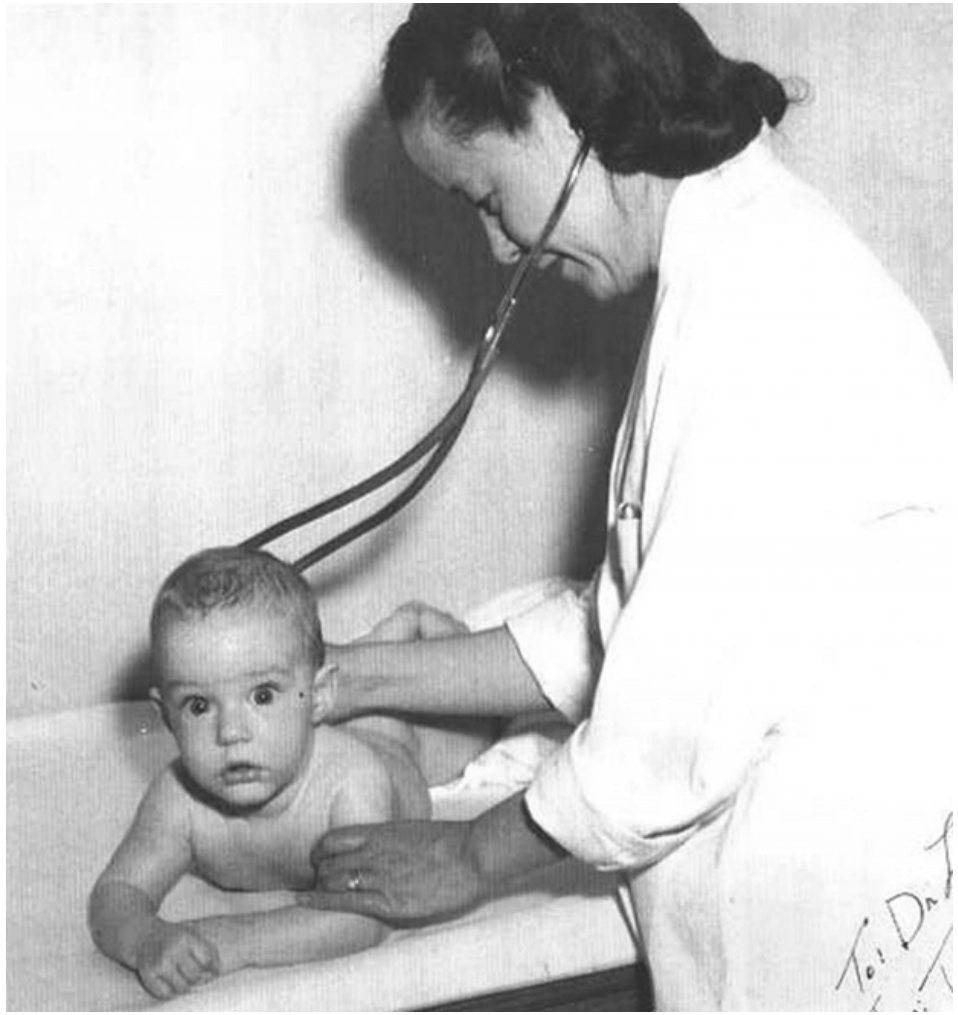
Stowe. J Clin Psychiatry 2007.

PMAD Risk Factors

- History of postpartum depression (50%)
- History of MDD (25-30%)
- Adolescent mother (25%)
- Marital conflict, IPV
- First time mother, twins
- Unplanned pregnancy
- Major life stressor, past trauma
- Poor support, low SES
- Issues with delivery, infant health, NICU
- Physician (25%)



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Beck. J Obstet Gyn Neo Nurs Jul 2002
Gaynes, Meltzer-Brody et al . Evid Rep Tech Feb 2005

Case 1:

- 32 year old woman presents after the birth of her first child 4 months ago.
- She reports feeling increased pressure and annoyance, particularly when the baby cries, leading to a preference for her husband or mother to respond.
- The patient reports feeling sad during the day and tends to worry when she has free time.
- She feels like she is not a good parent when she can't figure out why the baby is crying or how to make the baby comfortable.

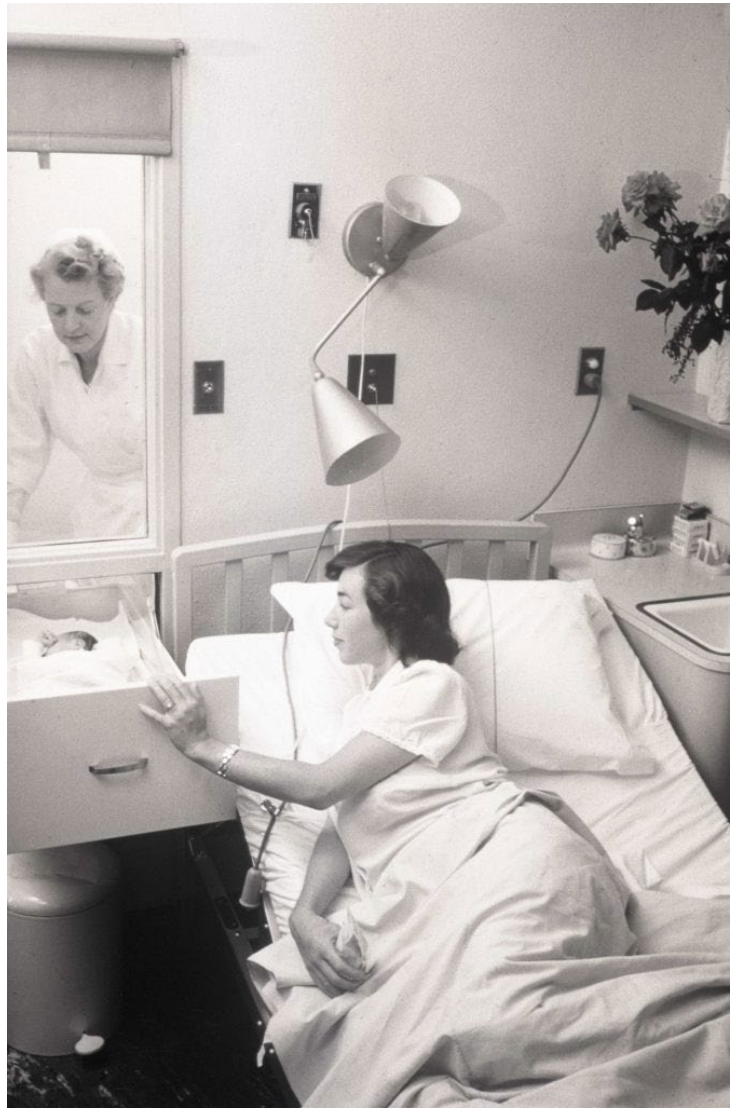
  – What follow up questions would you like to ask this patient? What screening measures would you like her to complete?

Case 1 continued:

- She describes her birth experience as “uneventful”. Her baby was delivered vaginally and is healthy.
- She struggled with breastfeeding and now pumps to relieve discomfort but is not producing significant amounts of milk.
- The baby sleeps for about five hours at night, during which the patient also tries to sleep, but often struggles to fall back asleep after the baby wakes up even if her husband assists with nighttime feeding.
- She has had occasional thoughts of self harm like "what if I crashed my car into traffic" but denies intent to act on these thoughts, citing her baby and family as protective factors. She has not had any thoughts about harm to her infant.
- She denies depression during her pregnancy, but was anxious as she had previously had a chemical pregnancy and worried about miscarriage.
- Has several psychosocial stressors.

Screening: Depression

- At least once during pregnancy
- At least once postpartum (ideally within 2 weeks of delivery)
- PHQ-9 (preferred over PHQ-2) – useful for pre-pregnancy comparison – cut off 12 or any SI
- Edinburgh Postnatal Depression Scale (EPDS) – omits somatic symptoms (appetite, energy level) – cut off 9 or SI
- Differentiate “baby blues” from depressive episode



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Landman et al Eur Psych April 2024

Screening: Anxiety

- General Anxiety Disorder 7 (GAD-7) – cut-off 10
- EDPS:
  - I have blamed myself unnecessarily when things went wrong
  - I have felt scared or panicky for no good reason
  - I have been anxious or worried for no good reason
- Assess level of impairment of parental worry

Screening: OCD

- Do you have intense thoughts or visions of bad things happening to your baby?
- Do you avoid doing day to day things with your baby: driving, bath time, shopping?
- Do you check on your baby frequently while she/he is sleeping? Do you have difficulty sleeping even when you have a chance?
- Do you clean things to excess (hands, bottles, pump parts)?
- Have you had any thoughts about hurting your baby?

Screening: PTSD

- PC-PTSD-5 – cut off 4
- Do you have any history of trauma?
- Were there any challenges or complications in your prior birth?
  - How do you feel when you think about it?
- Additional screening:
  - Previous miscarriage/stillbirth/child loss
  - Pre-eclampsia/HELLP/postpartum hemorrhage
  - Infant-related/NICU
- Always screen for IPV

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Case 1: resolved

- Patient had been prescribed fluoxetine, but felt like it wasn't working.
- Had started rifampin at 2 months postpartum for treatment of latent tuberculosis.
- Increased fluoxetine, added a low dose of trazodone to help with sleep.
- Increased social support.

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Case 2:

- 37 year old woman who is 16 weeks pregnancy with her second child presents due to depression and anxiety.
- She has a history of MDD and anxiety; prior to her first pregnancy she took escitalopram and propranolol, which worked well. Has also tried gabapentin (worked well), hydroxyzine (too sedating), sertraline (increased anxiety), paroxetine (worked well but had side effects), lorazepam.
- Currently taking escitalopram 20 mg.
- Denies postpartum depression with first child, but baby was born at 36 weeks with delivery complicated by PPROM and spent time in the NICU. Patient notes she cannot remember a lot of this time period.
- Recently has had trouble sleeping, felt less patient, more in conflict with family members, has had thoughts of wishing she was dead in times of high stress, and felt hopeless.
  - How would you treat this patient?

General Principles

- Psychotherapy is first line for mild-moderate symptoms
- Use medications with data
  - Patient specific data
  - Reproductive safety data
  - Fewest meds at lowest dose to **fully treat** illness
- Make medication changes early
- Encourage stability / supports

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Perinatal Psychotherapy

- First line for mild-moderate symptoms
  - In conjunction with medications for moderate-severe symptoms

- Anxiety/depression: CBT, ACT, interpersonal (IPT), psychodynamic
- OCD: CBT with exposure, ERP
- PTSD: Perinatal-CPP

- Support groups: https://postpartum.net/get-help/psi-online-support-meetings/ and https://perinatalsupport.org/
- Warm line: Perinatal Support WA, call/text 1-888-404-7763

Pharmacotherapy

- Goal is to **fully treat the disorder**
- Risk vs risk conversation: risk of medication exposure **versus** risk of exposure to untreated maternal illness
- All medications transmit to the placenta in varying amounts
- No psychotropic is FDA approved for use in pregnancy
- Document:
  - All Rx, OTC meds, environmental and substance exposure in pregnancy
  - Previous pregnancy outcomes for preterm birth, birth defects and complications
  - Informed consent: including risk of meds and risks of psychiatric disorders
  - Plan to monitor symptoms and adverse events across pregnancy

SSRIs

- First-line treatment for depression, anxiety, PTSD and OCD during pregnancy and lactation
- No increased risk of congenital defects over typical pregnancy background risk of 3-5%
- SSRI use has not been causally linked with increased risk of miscarriage
- No increased risk for: neurodevelopmental disorders, autism, ADHD, learning disorders, behavioral disorders, low IQ
- No significant risk for cardiac defects, including paroxetine

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Kjaersgaard et al. PLoS One Aug 2013 *Brown et al. JAMA Psychiatry Nov 2016*
Suarez et al . JAMA Intern Med Oct 2022 *Furu et al. BMJ April 2015*

SSRIs: Risks

- Preterm birth/low birth weight: modest association
- Neonatal adaptation syndrome:10-30% of infants exposed to SSRIs show symptoms, 97% mild and transient
- Persistent pulmonary hypertension of the newborn: controversial, but likely small increase in absolute risk

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Bandoli et al. Pediatrics Jul 2020

Malm et al. Am J Psychiatry Dec 2015

Marroun et al. Arch Gen Psychiatry Jul 2012

Huybrechts et al. JAMA Jun 2015

So What SSRI Should I Order?

- The SSRI that worked for patient in the past
- If they haven't tried anything before: sertraline (preferred for breastfeeding)

SSRIs[b]				
Citalopram (Celexa)	10	Increase to 20 mg/day after one week Then, increase by 10-20 mg every 4 weeks[c] (max dose 40 mg/day)[d]	SSRIs not associated with increase in malformations May need dosage increase later in pregnancy Possible increased risk of persistent pulmonary hypertension of the newborn (PPHN); 2.9/1000 vs. 1.8/1000 baseline; lowest risk with sertraline Transient neonatal adaptation syndrome (NAS) in 30% of exposed infants	RID[e] < 10%; reports of sedation, fussiness, weight loss in infants; monitor weight gain, behavioral effects
Escitalopram (Lexapro)	5	Increase to 10 mg/day after one week Then, increase to 20 mg/day after 4 weeks[c] (max dose 20 mg/day)		RID[e] < 10%; one report of necrotizing enterocolitis; monitor for sedation, irritability
Fluoxetine (Prozac)	10	Increase to 20 mg/day after one week Then, increase by 10-20 mg every 4 weeks[c] (max dose 80 mg/day)		RID[e] may be > 10%; monitor for behavioral effects, adequate weight gain
Paroxetine (Paxil)	10	Increase to 20 mg/day after one week Then, increase dose by 10-20 mg every 4 weeks[c] (max dose 50 mg/day)		RID[e] generally 5% or less; few adverse effects; monitor for agitation, irritability, poor feeding, poor weight gain
Sertraline (Zoloft)	25	Increase to 50 mg/day after one week Then, increase by 25-50 mg every 4 weeks[c] (max dose 200 mg/day)		Low concentrations in breast milk and infant; RID[e] generally 2% or less; few adverse effects in infants; considered preferred antidepressant in breastfeeding

UW Perinatal Mental Health Care Guide

SNRIs

- Most patients who have stabilized on SNRI can stay on SNRI
- Venlafaxine and duloxetine have some data; limited data for newer SNRIs
- Controversy around birth defects with venlafaxine
- Similar risk for neonatal adaptation syndrome as the SSRIs
- SNRIs associated with 1.5 fold increased risk of preeclampsia in earlier studies
  - In later studies, duloxetine specifically did not show an increased risk of preeclampsia
  - Blood pressure monitoring recommended, especially with increasing doses
- SNRI exposure may be a minor risk factor for postpartum hemorrhage, but causation has not been established

Anderson et al. JAMA Psych Dec 2020
Huybrechts et al. BMJ Feb 2020
Palmsten et al. Epidemiology Sep 2013
Bobo et al. Hum Psychopharm Sep 2025

Other antidepressants:

- Mirtazapine
  - No increased risk of major malformations, miscarriage or stillbirth
- Buproprion
  - No increase in major malformations; some studies show small increase in left ventricular outflow tract obstructions with an absolute risk of 2-3 per 1000 births
- Newer antidepressants (vortioxetine, vilazodone): limited reproductive data
- TCAs
  - No increased risk for major malformations with exception of clomipramine (cardiac)
  - Neonatal toxicity: reports of irritability, tachypnea, anticholinergic effects, seizures (clomipramine)

Ostenfeld et al. Acta Psy Scan Jun 2022
Alwan et al. Am Journ Ob and Gyn Jul 2010
Wichman & Stern. Pri Car Comp Apr 2015

Zuranolone:

- Positive allosteric modulator of the GABA-A receptor
- Indicated for postpartum depression, not for use during pregnancy
- Typical dosing 50 mg x 14 days; lower dose if sedating (40 mg)
- Limited data re: breastfeeding
- Prior authorization currently and only available through select specialty pharmacies

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Price et al. J Clin Psych Jul 2025

Anxiety Medications

Gabapentin

- Limited but accumulating evidence; no increased risk of major malformations; small increase in risk of cardiac malformations, preterm birth, NICU admission and infants who were small for gestational age.

Pregabalin

- Few small studies with mixed reports re: risk of malformations; manufacturer recommends against breastfeeding.

Buspirone

- Limited peripartum and lactation data; no major malformations reported.

Hydroxyzine

- Limited perinatal data; supratherapeutic doses associated with congenital risks in animal models
- Reasonable to use in occasional small doses in lactation, but may decrease milk supply

Quetiapine

- No increased risk of major malformations, increased risk of gestational diabetes. Low levels in breast milk.

Patorno et al. PLoS Med Sep 2020
Andrade. J Clin Psych Sep 2018
Freeman et al. Arch Wom Ment Health Jul 2022
Hansen et al. Birth Defect Res Oct 2020
Cohen et al. J Womens Health Jan 2023.

Benzodiazepines

- Older studies suggested increased risk of cleft lip/palate, largely refuted by newer studies which suggest no increased risk of major malformations
- Newer studies have suggested increased risk of miscarriage, but with confounders
- May increase risk of preterm birth and low birth weight infants, increased rate of NICU admission
- Risk for neonatal toxicity/withdrawal, “floppy baby”
- Lorazepam is preferred agent (lower placental passage and RID); no need to pump and dump; advise against co-sleeping

Grigoriadis et al. J Clin Psych Jul 2019

Sheehy et al. JAMA Psych May 2019

Chuang et al. Lancet Psych Aug 2024

PTSD Medications

- Would avoid:
  - Clonidine
    - Limited evidence; what is available shows no increased risk of major malformations
    - Associated with decreased fetal growth, withdrawal symptoms
    - Use during lactation not recommended
  - Prazosin
    - Limited data; concerns about risk for maternal hypotension and fetal growth
  - Propranolol
    - Controversy regarding risks of malformations
    - Limited data in breastfeeding

Ornoy. Pharm Res Feb 2018

Davidson Gen Hosp Psych Jul 2021

Perinatal Insomnia

- Disrupted sleep affects most pregnancies
- Most significant disruption is third trimester and postpartum
- Associated with increased blood pressure, increased BMI, peripartum depression and anxiety
- First-line treatment: encourage sleep hygiene, rule out underlying medical conditions, CBT-I

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Sleep Medications

- Unisom (doxylamine): first line, 12.5-25 mg
- Melatonin is generally not favored in pregnancy
- Trazodone: limited data, but available data with no evidence for harm; compatible with breastfeeding
- Mirtazapine
- Gabapentin
- Low dose quetiapine in certain cases
- Benzodiazepines: reasonable for short-term use postpartum
- Z-drugs: no evidence of major malformations; may be associated with increased risk of pre-term birth, low birth weight

Dao et al. J Clin Psych Nov 2022

Fung et al. JAMA Psych Dec 2025

Case 2: resolved

- Depression was more prominent than anxiety, so added buproprion XL 150 mg in the morning as an adjunct to escitalopram 20 mg daily
- Started doxylamine 25 mg nightly PRN for sleep
- Invited partner to attend session for psycho-education
- Increased supports, discussed switch to trauma-focused therapy surrounding labor and birth

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Case 3

- Patient presents at 15 weeks of pregnancy with chief complaint of anxiety. Pregnancy has been complicated by IUGR and Toxoplasmosis exposure. Patient's pre-pregnancy medications included naltrexone 50 mg daily, sertraline 100 mg daily, lamotrigine 200 mg daily, aripiprazole 15 mg daily, clonazepam 0.5 mg daily, dextroamphetamine 30 mg daily, and gabapentin 900 three times daily.
  - How would you treat this patient?

Refer to psychiatry!

Resources

Medication information for patients

- mothertobaby.org

Medication information for you:

- LactMed
- “Medications & Mother's Milk”: https://halesmeds.com
- MGH Center for Women’s Health: https://womensmentalhealth.org/

More training:

- NCRP: https://ncrptraining.org/ncrp-intensive/

Questions?