Managing Anxiety Disorders in the Primary Care Setting

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July 20, 2023 CME/CE Dinner Event, 6:30 pm-8:30 pm
Directly Provided CME/CE Activity by L.A. Care Health Plan
2 CME/CE Credits

Disclosures

The following CME Planners and CME Faculty do not have any financial relationships with ineligible companies in the past 24 months.

- Leilanie Mercurio, L.A. Care PCE Program Manager, CME Planner.
- Christopher T. Benitez, MD, Outpatient Medical Director, Riverside University Health System, Behavioral Health; Associate Professor of Psychiatry, Loma Linda University; CME Planner and Faculty.

An ineligible company is any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Commercial support was not received for this CME activity.

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Learning Objectives

At the completion of the activity, learners can:

- List at least one evidence-based screening tool to identify anxiety disorders in primary care.
- Identify common presentations /symptoms of anxiety in primary care.
- Formulate a treatment plan for anxiety that includes pharmacological strategies and/or non-pharmacological strategies.
- Identify at least two strategies for management of anxiety disorders.

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How should primary care providers participate in management of their patient's psychiatric conditions?

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Primary care is the *de facto* mental health system

FOR GOOD REASON

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Providing quality mental health services in the primary care setting is BEST FOR THE PATIENT

What is needed is SUPPORT for primary care providers in doing this well

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Mental Health:
What's the best way to start?

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From the beginning, of course

…and with questions

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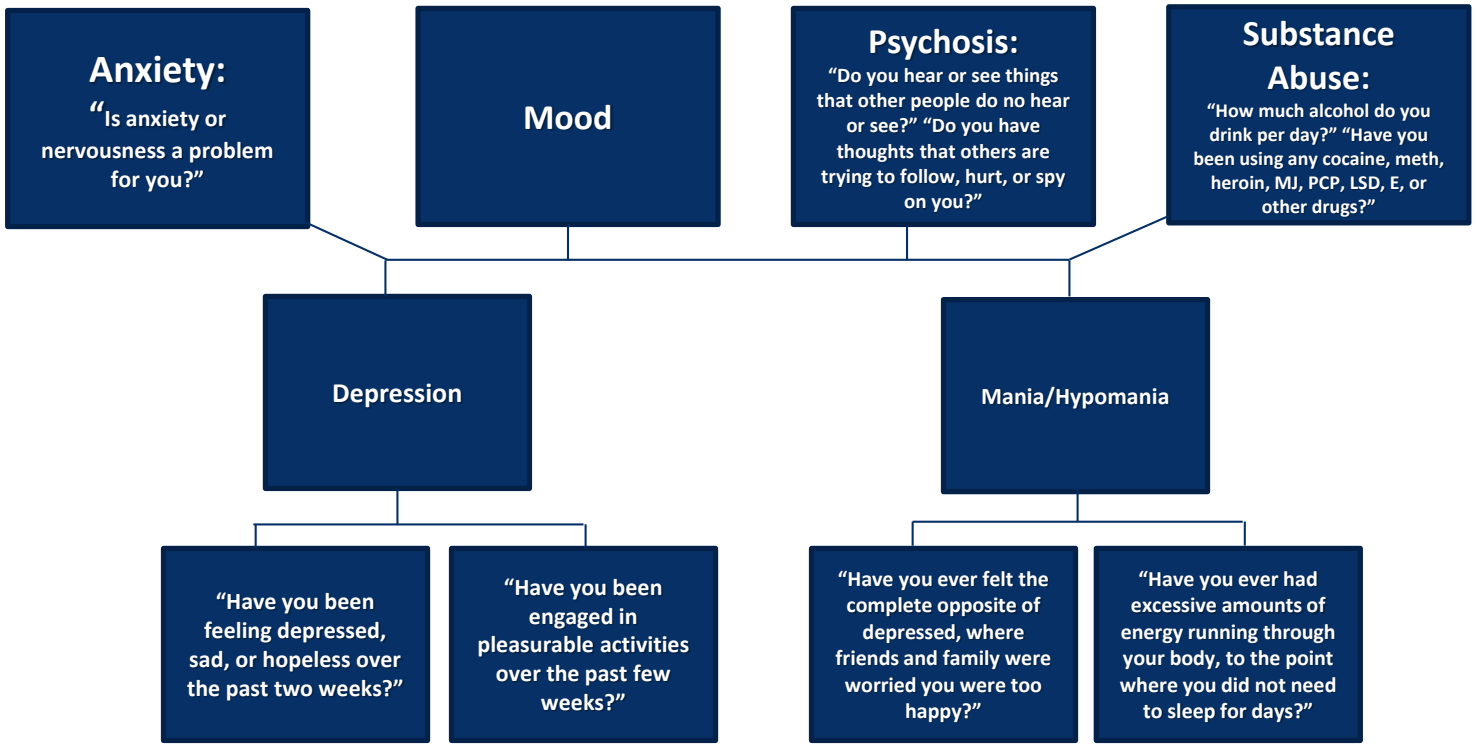
AMPS
Mental Health Mnemonic



Lippincott's Primary Care Psychiatry. Robert M. McCarron, Glen L. Xiong, James A. Bourgeois. Lippencott, William and Wilkens, 2009.

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Are we ever going to get to anxiety?

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YOU WORRY TOO MUCH... IT DOESN'T DO ANY GOOD...
IT DOES FOR ME... 95% OF THE THINGS I WORRY ABOUT NEVER HAPPEN!

Some Definitions

Anxiety:

- An unpleasant emotional state for which the cause is either not readily identified or perceived to be uncontrollable or unavoidable
- Excessive worrying, nervousness, or feeling "on edge"

Fear:

- An emotional and physiologic response to a recognized external threat.

Anxiety Symptoms: ***can be normal***

- Common in the general population
- Can be mild, transient, and without impairment
- Can be triggered/provoked

Anxiety Disorders:

- Significant and uncontrollable feelings of anxiety and fear such that a person's social, occupational, and personal function are significantly impaired.

Diagnostic and statistical manual of mental disorders 5th edition: DSM-5. Arlington, VA Washington, D.C: American Psychiatric Association. 2013. p. 189–195. ISBN 978-0-89042-555-8. OCLC 830807378.

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Anxiety Disorders: Prevalence and Severity

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Anxiety Prevalence (US adults)

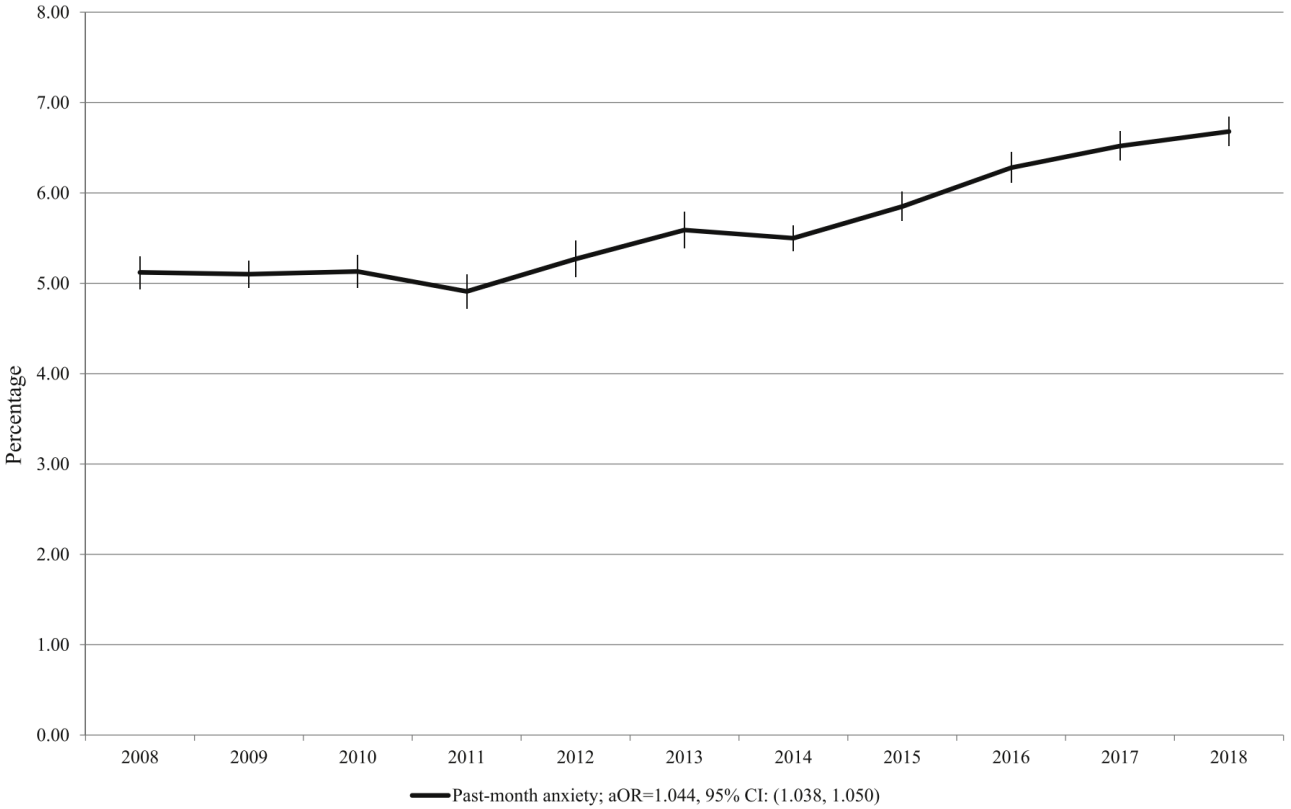

Fig. 1. Prevalence of past-month anxiety from 2008 to 2018 (NSDUH, US adults ages 18 years and older)[a].
Abbreviations: aOR, adjusted odds ratio; CI, confidence interval; NSDUH, National Survey on Drug Use and Health.
[a]Anxiety was operationalized as self-reported nervousness in the past month most of the time or all of the time.
Note: Odds ratio for calendar yearly linear trend was adjusted for age, gender, race/ethnicity, income, marital status, and educational attainment.

Goodwin RD, Weinberger AH, Kim JH, Wu M, Galea S. Trends in anxiety among adults in the United States, 2008-2018: Rapid increases among young adults. J Psychiatr Res. 2020 Nov;130:441-446. doi: 10.1016/j.jpsychires.2020.08.014. Epub 2020 Aug 21. PMID: 32905958; PMCID: PMC7441973

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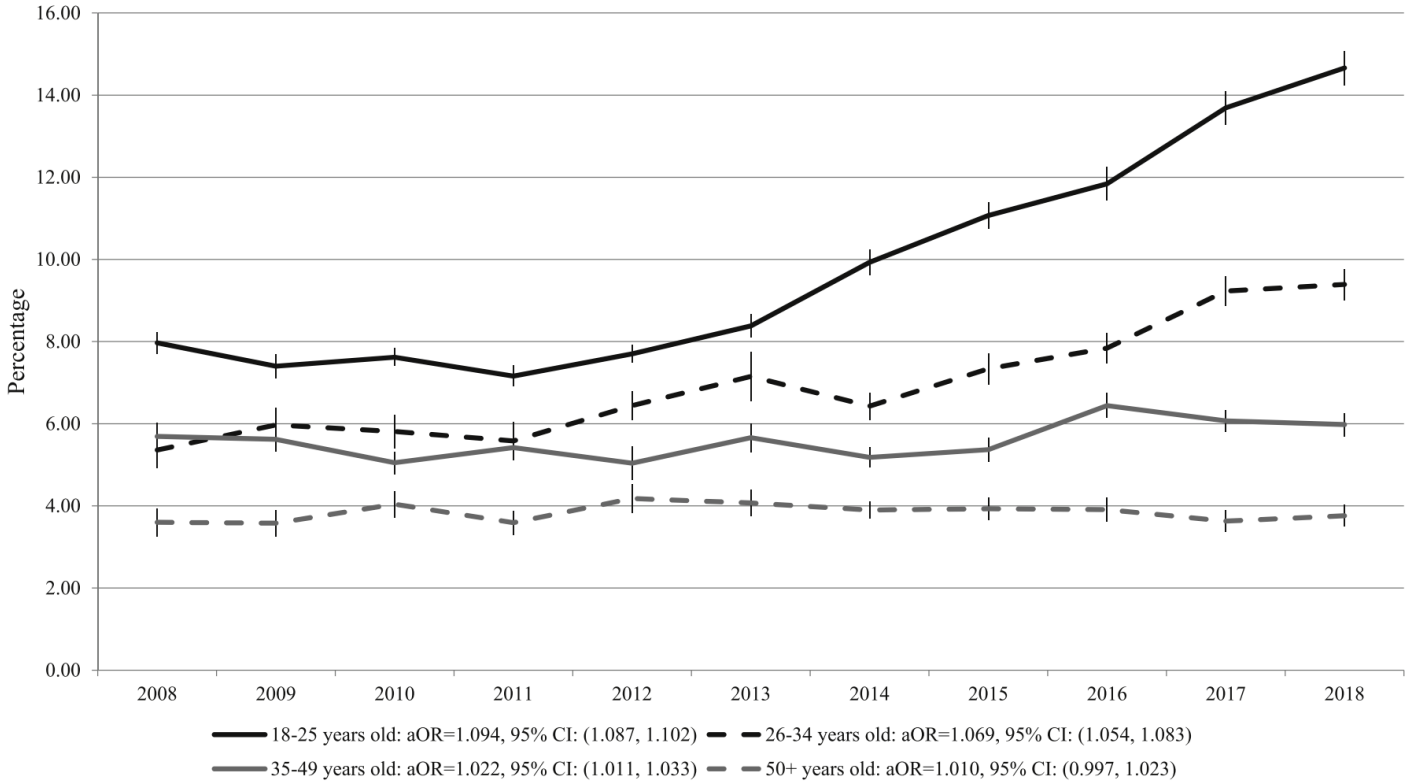
Anxiety Prevalence (by Age)



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Anxiety Disorder Prevalence

Table 2. 12-month prevalence of DSM-IV/WMH-CIDI disorders by sex and cohort [1] (n=9282)

12-month	Total		Sex				Cohort							
			Female		Male		18-29		30-44		45-59		60+	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
I. Anxiety Disorders														
Panic disorder	2.7	(0.2)	3.8	(0.3)	1.6	(0.2)	2.8	(0.4)	3.7	(0.5)	3.1	(0.4)	0.8	(0.2)
Agoraphobia without panic[7]	0.9	(0.1)	0.9	(0.2)	0.8	(0.2)	1.0	(0.2)	0.8	(0.2)	1.2	(0.3)	0.4	(0.1)
Specific phobia	9.1	(0.4)	12.2	(0.5)	5.8	(0.5)	10.3	(0.8)	9.7	(0.6)	10.3	(0.9)	5.6	(0.5)
Social phobia	7.1	(0.3)	8.0	(0.5)	6.1	(0.5)	9.1	(0.7)	8.7	(0.7)	6.8	(0.6)	3.1	(0.3)
Generalized anxiety disorder[7]	2.7	(0.2)	3.4	(0.2)	1.9	(0.3)	2.0	(0.3)	3.5	(0.3)	3.4	(0.3)	1.5	(0.3)
Post-traumatic stress disorder[2]	3.6	(0.3)	5.2	(0.4)	1.8	(0.3)	4.0	(0.5)	3.5	(0.5)	5.3	(0.6)	1.0	(0.2)
Obsessive-compulsive disorder[3]	1.2	(0.3)	1.8	(0.5)	0.5	(0.2)	1.5	(0.4)	1.4	(0.6)	1.1	(0.6)	0.5	(0.3)
Adult separation anxiety disorder[2]	1.9	(0.2)	2.1	(0.2)	1.7	(0.3)	4.0	(0.5)	2.2	(0.3)	1.3	(0.3)	0.1	(0.1)

Table 1. Lifetime prevalence of DSM-IV/WMH-CIDI disorders by sex and cohort [1] (n=9282)

Lifetime	Total		Sex				Cohort							
			Female		Male		18-29		30-44		45-59		60+	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
I. Anxiety Disorders														
Panic disorder	4.7	(0.2)	6.2	(0.3)	3.1	(0.3)	4.2	(0.5)	5.9	(0.6)	5.9	(0.4)	2.1	(0.4)
Agoraphobia without panic[6]	1.3	(0.1)	1.6	(0.2)	1.1	(0.2)	1.2	(0.3)	1.4	(0.2)	1.8	(0.3)	0.9	(0.2)
Specific phobia	12.5	(0.4)	15.8	(0.6)	8.9	(0.6)	13.0	(0.9)	13.9	(0.7)	14.4	(1.0)	7.7	(0.6)
Social phobia	12.1	(0.4)	13.0	(0.6)	11.1	(0.6)	13.3	(0.7)	14.5	(0.9)	12.6	(0.9)	6.8	(0.5)
Generalized anxiety disorder[6]	5.7	(0.3)	7.1	(0.3)	4.2	(0.4)	4.3	(0.4)	6.5	(0.5)	7.6	(0.7)	4.0	(0.4)
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Adult/Child separation anxiety disorder[2]	9.2	(0.4)	10.8	(0.6)	7.4	(0.5)	12.4	(0.9)	11.1	(0.7)	9.2	(0.8)	3.1	(0.5)
Any anxiety disorder[5]	31.2	(1.0)	36.4	(1.1)	25.4	(1.2)	32.9	(1.3)	37.0	(1.5)	34.2	(1.7)	17.8	(1.4)

https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder#:~:text=Past%20year%20prevalence%20of%20any%20anxiety%20disorder%20was,anxiety%20disorder%20at%20some%20time%20in%20their%20lives.2.

Baldwin DS, et. al. Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: a revision of the 2005 guidelines from the British Association for Psychopharmacology. J Psychopharmacol. 2014 May;28(5):403-39. doi: 10.1177/0269881114525674. Epub 2014 Apr 8. PMID: 24713617.

Ansseau M. et. al. High Prevalence of Mental Disorders in Primary Care. *J. Aff. Disorders.* 2004 Jan; 78(1):49-55

Nisenson LG. et. al. The Nature and Prevalence of Anxiety Disorders in Primary Care. *Gen. Hosp. Psych.* 1998 Jan; 20(1) 21-28

Harvard Medical School, 2007. National Comorbidity Survey (NCS). (2017, August 21). Retrieved from https://www.hcp.med.harvard.edu/ncs/index.php.

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Agoraphobia without panic[7]	0.9	(0.1)	0.9	(0.2)	0.8	(0.2)	1.0	(0.2)	0.8	(0.2)	1.2	(0.3)	0.4	(0.1)
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Obsessive-compulsive disorder[3]	1.2	(0.3)	1.8	(0.5)	0.5	(0.2)	1.5	(0.4)	1.4	(0.6)	1.1	(0.6)	0.5	(0.3)
Adult separation anxiety disorder[2]	1.9	(0.2)	2.1	(0.2)	1.7	(0.3)	4.0	(0.5)	2.2	(0.3)	1.3	(0.3)	0.1	(0.1)
Any anxiety disorder[5]	19.1	(0.7)	23.4	(0.8)	14.3	(0.8)	22.3	(1.0)	22.7	(1.0)	20.6	(1.3)	9.0	(0.8)

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Agoraphobia without panic[6]	1.3	(0.1)	1.6	(0.2)	1.1	(0.2)	1.2	(0.3)	1.4	(0.2)	1.8	(0.3)	0.9	(0.2)
Specific phobia	12.5	(0.4)	15.8	(0.6)	8.9	(0.6)	13.0	(0.9)	13.9	(0.7)	14.4	(1.0)	7.7	(0.6)
Social phobia	12.1	(0.4)	13.0	(0.6)	11.1	(0.6)	13.3	(0.7)	14.5	(0.9)	12.6	(0.9)	6.8	(0.5)
Generalized anxiety disorder[6]	5.7	(0.3)	7.1	(0.3)	4.2	(0.4)	4.3	(0.4)	6.5	(0.5)	7.6	(0.7)	4.0	(0.4)
Post-traumatic stress disorder[2]	6.8	(0.4)	9.7	(0.7)	3.6	(0.3)	6.3	(0.6)	8.1	(0.9)	9.2	(0.8)	2.8	(0.5)
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Harvard Medical School, 2007. National Comorbidity Survey (NCS). (2017, August 21). Retrieved from https://www.hcp.med.harvard.edu/ncs/index.php.

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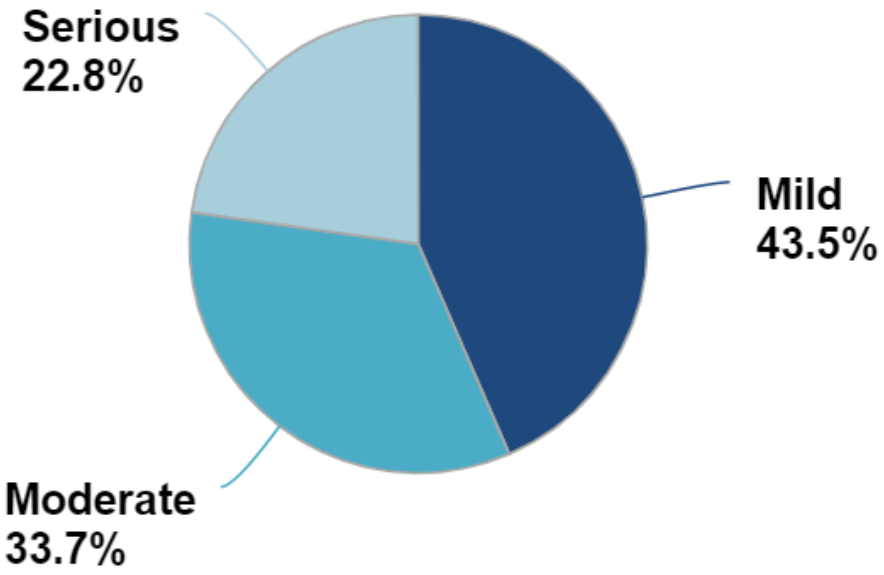
Severity

Past Year Severity of Any Anxiety Disorder Among U.S. Adults (2001–2003)

Data from National Comorbidity Survey Replication (NCS–R)



https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder#:~:text=Past%20year%20prevalence%20of%20any%20anxiety%20disorder%20was,anxiety%20disorder%20at%20some%20time%20in%20their%20lives.2. Harvard Medical School, 2007. National Comorbidity Survey (NCS). (2017, August 21). Retrieved from https://www.hcp.med.harvard.edu/ncs/index.php.

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Culture, Ethnicity, and Anxiety

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Anxiety Among US Ethnic Groups

- Asian Americans report < anxiety symptoms than other groups
- White Americans report > SAD, GAD and PD than AA and Latino Americans
- PTSD criteria:
  - African Americans > White > Latino > Asian Americans (8.6% > 6.5% > 5.6% > 1.6%)
  - Beliefs about the human body's biology and nature of psychological process are closely linked to culture-specific disorders e.g. "khyal attacks"

Asnaani A et. al. A cross-ethnic comparison of lifetime prevalence rates of anxiety disorders. Journal of Nervous and Mental Disease. 2010; 198:551–555. [PubMed: 20699719]

Hofmann SG, Hinton DE. Cross-cultural aspects of anxiety disorders. Curr Psychiatry Rep. 2014 Jun;16(6):450. doi: 10.1007/s11920-014-0450-3. PMID: 24744049; PMCID: PMC4037698.

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Impact of Racial Discrimination Perception on Psychiatric Disorders

- The perception of racial discrimination associated with endorsement for PD, Agoraphobia w/o PD, PTSD, MDD, SUD
- African Americans reported significantly higher rates of discrimination
  - And those reporting perceived racism were significantly more likely than Asian Americans to endorse PTSD over their lifetimes
- Hispanics who reported racial discrimination were more likely to report MDD compared to AA and Asian Americans.
- Latinos > Asians to meet criteria for PD Agoraphobia
- Asian Americans less likely to reports SUD than the other two groups

Chou T, Asnaani A, Hofmann SG. Perception of racial discrimination and psychopathology across three US ethnic minority groups. Cult Div Ethnic Min Psychol. 2012; 18:74–81.

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Culturally-Specific Anxiety Disorders

Ataques de Nervios

- Provoked by negative affect
- Rapid escalation of distress that can induce somatic and psychological symptoms, activate catastrophic cognitions
- Metaphoric networks associated with negative affect and distress eventuating into an attack
- Also an idiom of distress – common way of reacting to hearing bad news

Hofmann SG, Hinton DE. Cross-cultural aspects of anxiety disorders. Curr Psychiatry Rep. 2014 Jun;16(6):450. doi: 10.1007/s11920-014-0450-3. PMID: 24744049; PMCID: PMC4037698.

Culturally-Specific Anxiety Disorders

Taijin Kyofusho (TKS)

- Japanese and Korean culturally-specific expression of anxiety
- Fear of doing something that will embarrass the other person (as opposed to embarrass self in SAD) e.g. offensive odors, staring inappropriately, improper facial expression
- 3:2 male. Continuum from adolescent social concerns to delusional disorders

Hofmann SG, Hinton DE. Cross-cultural aspects of anxiety disorders. Curr Psychiatry Rep. 2014 Jun;16(6):450. doi: 10.1007/s11920-014-0450-3. PMID: 24744049; PMCID: PMC4037698.

Disparities

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Racial Disparities in Anxiety Management

The good news…

65% of all patients were offered treatment
(61% medications; 11% counseling).
No differences in odds of being offered treatment based on race

The bad news…

<13% of visits were offered talk therapy and
Non-Hispanic Black patients had ~½ the odds of being offered such treatment.
Hispanic patients had 15% lower odds of being offered anxiety treatment

Zvolensky, M. J., Garey, L., & Bakhshaie, J. (2017). Disparities in anxiety and its disorders. *Journal of Anxiety Disorders*, *48*, 1-5

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Screening for Anxiety and Other Mental Health Conditions

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To Screen or Not to Screen…

JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

Screening for Anxiety Disorders in Adults

US Preventive Services Task Force Recommendation Statement

Summary of Recommendations

Population	Recommendation	Grade
Adults 64 years or younger, including pregnant and postpartum persons	The USPSTF recommends screening for anxiety disorders in adults, including pregnant and postpartum persons.	B
Older adults (65 years or older)	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for anxiety disorders in older adults.	I

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So Which Screen?

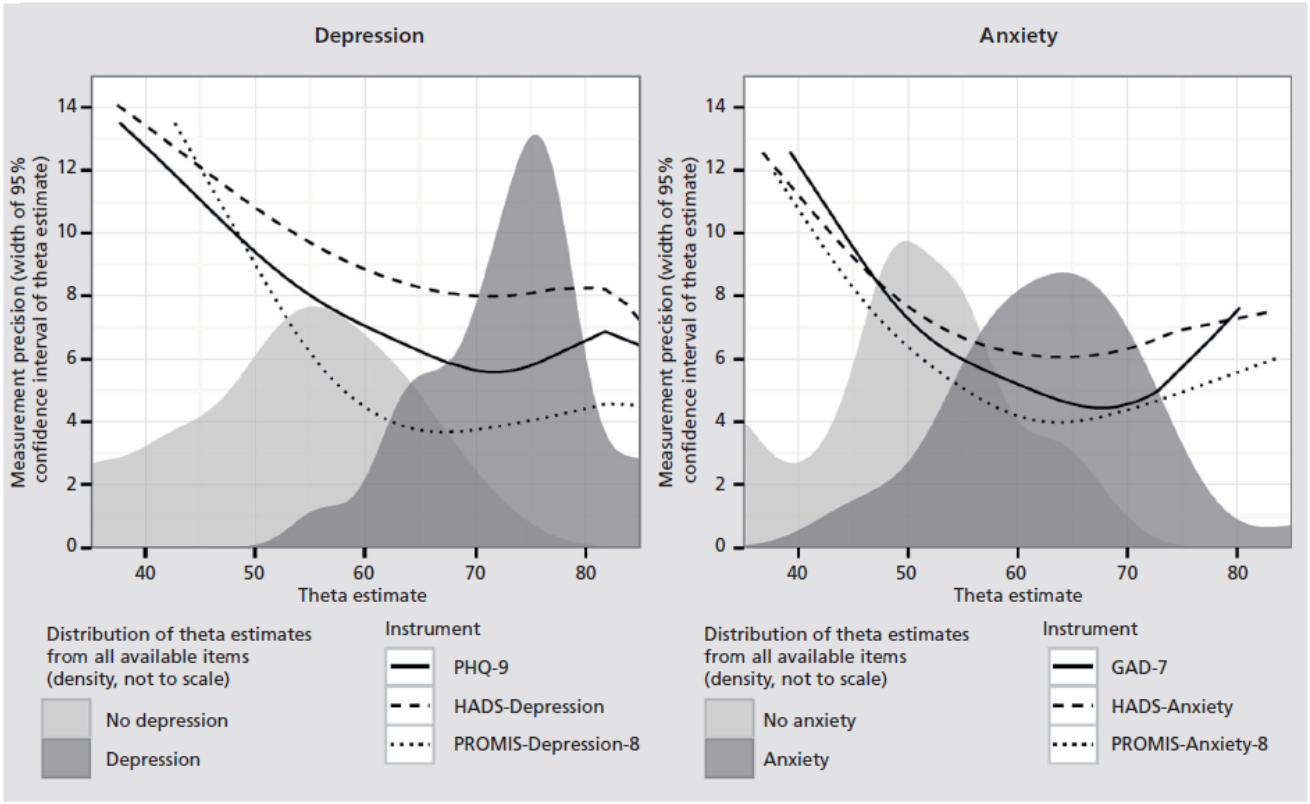

Figure 1. Example of the relation between measurement precision, measurement range of five psychometric instruments, and the distribution of the latent traits depression and anxiety in a sample of 194 heart failure patients with and without a comorbid mental disorder (for details see ref 106). PHQ, Patient Health Questionnaire; HADS, Hospital Anxiety and Depression Scale; PROMIS, Patient-Reported Outcomes Measurement Information System

Adapted from ref 106: Fischer HF, Klug C, Roeper K, et al. Screening for mental disorders in heart failure patients using computer-adaptive tests. *Qual Life Res.* 2014;23:1609-1618. Copyright © Springer Science + Business Media 2014

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4140513/pdf/DialoguesClinNeurosci-16-197.pdf

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Screening Tests

Instrument	Domains	Number of items	Recall period	Time to complete	Psychometric properties
>1000 citations					
State Trait Anxiety Inventory (STAI)[66,107]	Anxiety (state and trait)	20 state and 20 trait items	Currently and generally	4-8 min per scale	Good psychometric properties (internal consistency, 0.86-0.95; retest reliability, 0.65-0.89; proven validity: sensitivity, 0.82; specificity, 0.88), short versions. Norm data available.

STAI

GAD-7

100-1000 citations					
Generalized Anxiety Disorder–7 (GAD-7)[18,108]	Anxiety (items reflect DSM-IV criteria for GAD)	7 anxiety items	Over the last 2 weeks	5 min	Good psychometric properties (internal consistency, 0.89; good reliability and convergent validity: sensitivity, 0.80; specificity, 0.86). Norm data available.

<100 citations					
Patient Health Questionnaire–4 (PHQ-4)[20,67]	Anxiety and depression	2 anxiety and 2 depression items	Last 2 weeks	2 min	Moderate psychometric properties for anxiety scale (internal consistency, 0.75; sensitivity, 0.86, specificity, 0.70). Norm data available.

PHQ-4

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4140513/pdf/DialoguesClinNeurosci-16-197.pdf

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GAD-7

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

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More on GAD-7

Score	Risk Level	Suggested Intervention
0-4	No to Low risk	None
5-9	Mild	Repeat on follow-up
10-14	Moderate	Further evaluation required. Consider adjusting treatment plan.
15+	Severe	Adjust treatment plan. Higher level of care needed. Pharmacology re-evaluation.

- Cut off point ≥8: Sensitivity 0.83 Specificity 0.84
- Associated with medical outcomes and disability days
- Depression and anxiety
  - Frequently co-occur
  - Independent effects on functional impairment and disability

Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. doi: 10.1001/archinte.166.10.1092. PMID: 16717171.

Plummer F. et. al. Screening for Anxiety Disorders with the GAD-7 and GAD-2: A Systematic Review and Diagnostic Metaanalysis. *Gen. Hosp. Psych.* 2016 Mar-Apr; 39:24-31

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PHQ-4

TABLE 3. Factorial Validity of the PHQ–4 in 2,103 Patients

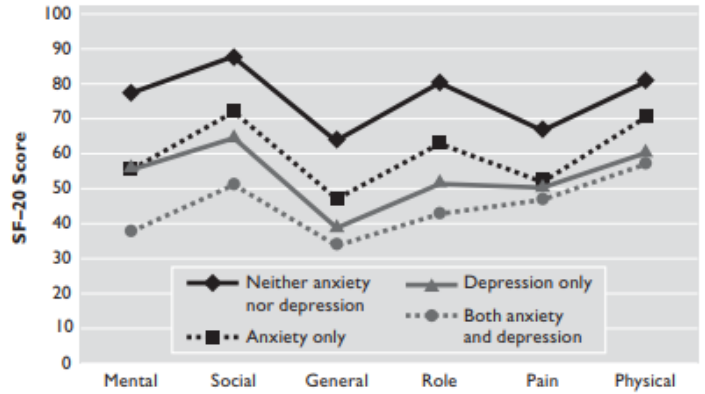
	Factor Loadings	
	Factor 1 (Anxiety)	Factor 2 (Depression)
Depression Items (PHQ–2)		
Little interest or pleasure in doing things	0.25	**0.90**
Feeling down, depressed, or hopeless	0.40	**0.82**
Anxiety Items (GAD–2)		
Feeling nervous, anxious, or on edge	**0.87**	0.29
Not being able to stop or control worrying	**0.86**	0.33

Principal-component analysis with varimax rotation. For each item, higher factor loadings are printed in bold.

Cutoff ≥ 3

Sensitivity 0.86
Specificity 0.8

FIGURE 2. Relationships Among Anxiety, Depression, and Functional Status



Kroenke K, Spitzer RL, Williams JB, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4. Psychosomatics. 2009 Nov-Dec;50(6):613-21. doi: 10.1176/appi.psy.50.6.613. PMID: 19996233.

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What About Screening for Suicide Risk?

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Suicide Facts

Over 50% of those who die by suicide have seen their PCP within one month of doing so.

Women attempt suicide 4x more than men.

Men succeed 3x more than women.

Firearms are involved in the majority of completed suicides (57% overall, 62% of men)

Ask your patients about access – suicide rates are increased 4-10x in adolescents with guns in the home

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Suicide Screen

Why screen?

- Screening will not increase risk of SI or suicidal behavior
- Patients may disclose SI and thus receive help in advance of an attempt.

Why not?

- Screening may not prevent any suicidal ideation or behaviors
- Concerns about proximate suicide attempts/completion

VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide. Version 2.0 - 2019

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What do we do with a positive screen for SI (#9 on the PHQ-9)?

Item 9: "Over the past two weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?"

1. Not at all
2. Several days
3. More than half the days
4. Nearly every day

Louzon SA, Bossarte R, McCarthy JF, Katz IR. Does suicidal ideation as measured by the PHQ-9 predict suicide among VA patients? Psychiatr Serv. May 1 2016;67(5):517-522

Simon GE, Rutter CM, Peterson D, et al. Does response on the PHQ-9 depression questionnaire predict subsequent suicide attempt or suicide death? Psychiatr Serv. Dec 1 2013;64(12):1195-1202.

Runeson B, Odeberg J, Pettersson A, Edbom T, Jildevik Adamsson I, Waern M. Instruments for the assessment of suicide risk: A systematic review evaluating the certainty of the evidence. PLoS One. 2017;12(7):e0180292.

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Item #9 continued…

TABLE 2. Timing of suicide deaths relative to the most recently completed PHQ-9 assessment among 391,492 VHA users, by response to item 9[a]

					Timing of suicide deaths (N=310)													
	Total users (N=391,492)		Suicide deaths (N=310)		Same day		≤7 days		≤30 days		≤60 days		≤90 days		≤180 days		≤1 year	
						Row		Row		Row		Row		Row		Row		Row
Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Not at all	343,635	87.8	222	71.6	0	—	3	1.4	19	8.6	33	14.9	51	23.0	92	41.4	160	72.1
Several days	30,570	7.8	49	15.8	0	—	1	2.0	6	12.2	9	18.4	11	22.4	18	36.7	40	81.6
More than half the days	8,698	2.2	17	5.5	0	—	2	11.8	2	11.8	7	41.2	8	47.1	10	58.8	14	82.4
Nearly every day	8,589	2.2	22	7.1	0	—	0	.0	4	18.2	4	18.2	5	22.7	13	59.1	17	77.3
Total					0	—	6	1.9	31	10.0	53	17.1	75	24.2	133	42.9	231	74.5

[a] PHQ-9, nine-item Patient Health Questionnaire; VHA, Veterans Health Administration

Louzon SA, Bossarte R, McCarthy JF, Katz IR. Does suicidal ideation as measured by the PHQ-9 predict suicide among VA patients? Psychiatr Serv. May 1 2016;67(5):517-522

Simon GE, Rutter CM, Peterson D, et al. Does response on the PHQ-9 depression questionnaire predict subsequent suicide attempt or suicide death? Psychiatr Serv. Dec 1 2013;64(12):1195-1202.

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When a patient reports current SI or history of attempts…

- Semi-structured interview of recent suicide ideation and chronic history of suicide attempts
- Unstructured conversation about recent stressors and current complaints using supportive listening techniques
- Collaborative identification of clear signs of crisis (behavioral, cognitive, affective or physical)
- Self-management skill identification including things that can be done on the patient's own to distract or feel less stressed
- Collaborative identification of social support including friends and family members who have helped in the past and who they would feel comfortable contacting in crisis
- Review of crisis resources including medical providers, other professionals and the suicide lifeline (1-800-273-8255)
- Referral to treatment including follow up appointments and other referrals as needed
- Consider protective factors
- Additional steps for management of military Service Members
  - Inform command
  - Determine utility of command involvement
  - Address barriers to care (including stigma)
  - Ensure follow-up during transition
  - Enroll in risk management tracking)

VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide. Version 2.0 - 2019

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Assessing Risk for Suicide: Risk Factors

PSYCHIATRIC DISORDERS (multiple comorbid d/o and recent hospitalization)

HOPELESSNESS & IMPULSIVITY (impulsive acts can result serious injury/death)

HISTORY OF ATTEMPTS (50% suicides made prior attempt)

AGE, SEX, RACE (older white males)

MARITIAL STATUS
(single, never married>widowed>separated>divorced)

OCCUPATION (unemployed and unskilled)

HEALTH (risk increases with physical illness, recent surgery, chronic or terminal disease and pain)

FAMILY HISTORY (6X increase risk, genetic & environment)

ACCESS TO WEAPONS

LESBIAN, GAY OR BISEXUAL ADOLESCENTS (report more suicidal ideation)

RECENT LOSS (physical, financial, personal)

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Assessing Risk for Suicide: Protective Factors

- Social support & connectedness
- Pregnancy & motherhood
- Religiosity & active participation
- Positive therapeutic relationship
- Mature problem-solving skills

Document Risk/Protective factors and make a concluding statement about acute risk.

Low, Moderate, High

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)

988

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Final Thoughts on Screening in the Primary Care Setting

- It's a good idea
- Do it well
  - Screening Workflows
  - Training
  - Tools (e.g. templated evaluation forms)
- Establish pathways for responding to positive screens

VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide. Version 2.0 - 2019

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Back to Anxiety

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Common Presentations

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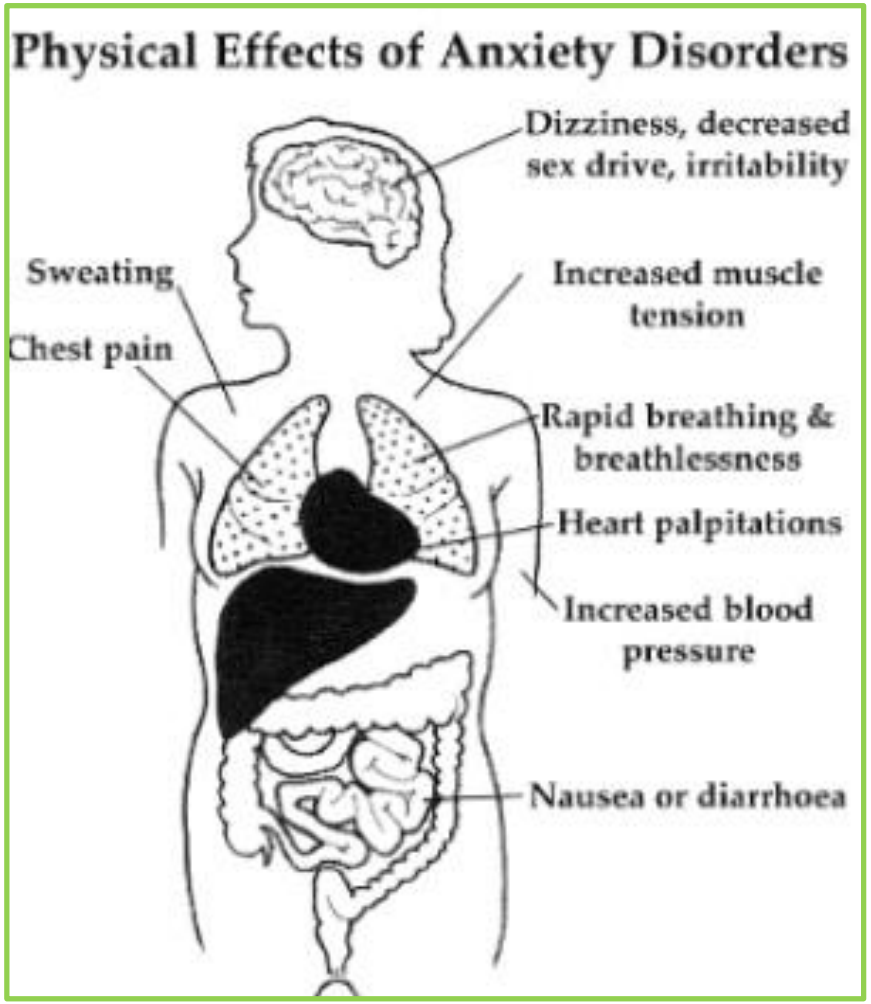
Anxiety Presentations in Primary Care



Presentation types

1. Psychiatric
2. Somatic
3. "High Utilizers"

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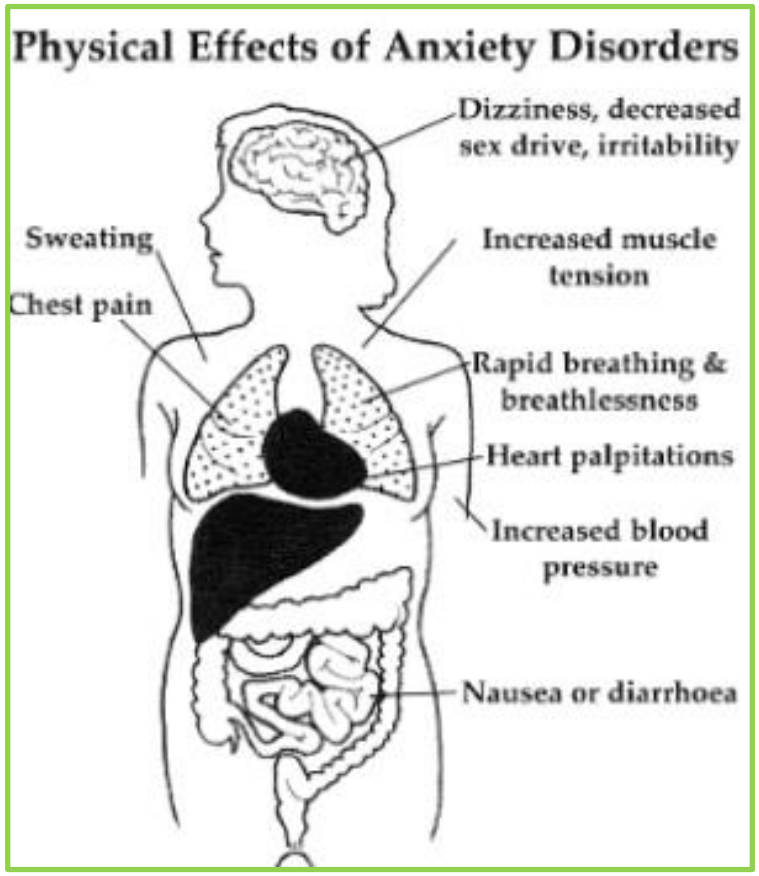
Culpepper, L. MD,MPH "Use of Algorithms to Treat Anxiety in Primary Care", J Clin Psychiatry 2003;64.

1. Psychiatric Presentations



Patients label their own symptoms as a specific disorder…
and sometimes they are right!

But make sure you ask questions…
because sometimes they are wrong.

Be sure to rule out other anxiety disorders, depression, and medical conditions!

Culpepper, L. MD,MPH "Use of Algorithms to Treat Anxiety in Primary Care", J Clin Psychiatry 2003;64.

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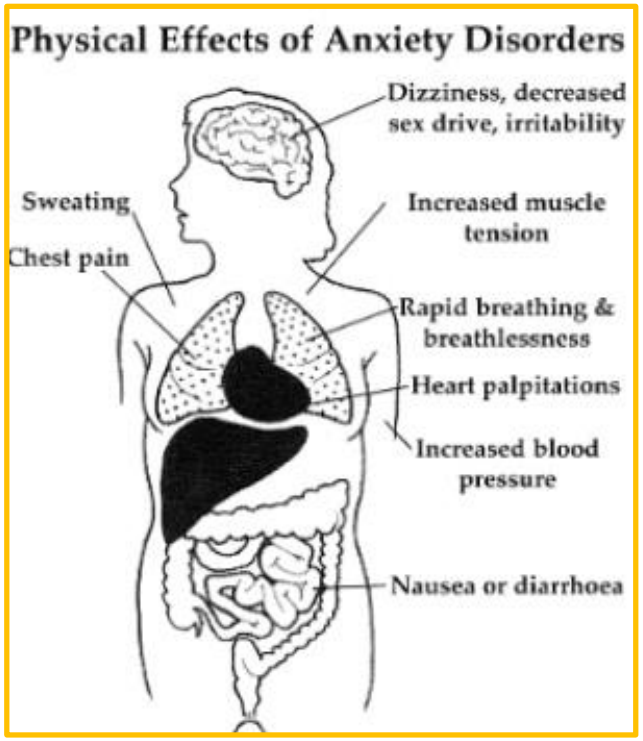
2. Somatic Presentations



- More common than the psychiatric presentation in PC settings
- Patients often do not consider psychiatric causes
- Normalizing attribution misdiagnosis

Other physical symptoms

- Fatigue
- Restlessness
- Tremors

Lippincott's Primary Care Psychiatry. Robert M. McCarron, Glen L. Xiong, James A. Bourgeois. Lippincott, William and Wilkens, 2nd Ed. 2018

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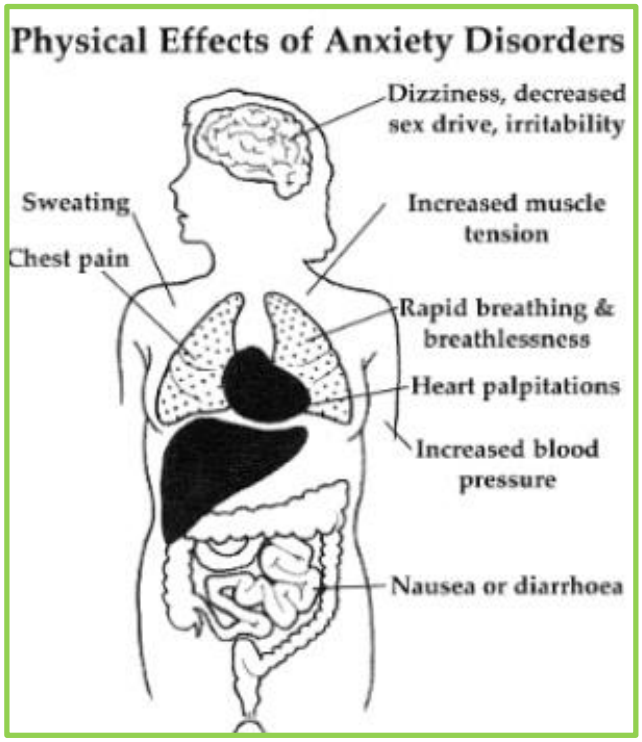
3. "High-Utilizer" Presentations



Frequent visits + Multiple complaints

Overrepresentation and Frustration

Humility is critical

Culpepper, L. MD,MPH "Use of Algorithms to Treat Anxiety in Primary Care", J Clin Psychiatry 2003;64.

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Differentiating Anxiety Disorders

Who wants me to go through the DSM?

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DIFFERENCE B/W NORMAL WORRY AND GAD

NORMAL "WORRY"

- Your worrying doesn't get in the way of your daily activities and responsibilities.
- You're able to control your worrying.
- Your worries, while unpleasant, don't cause significant distress.
- Your worries are limited to a specific, small number of realistic concerns.
- Your bouts of worrying last for only a short time period.

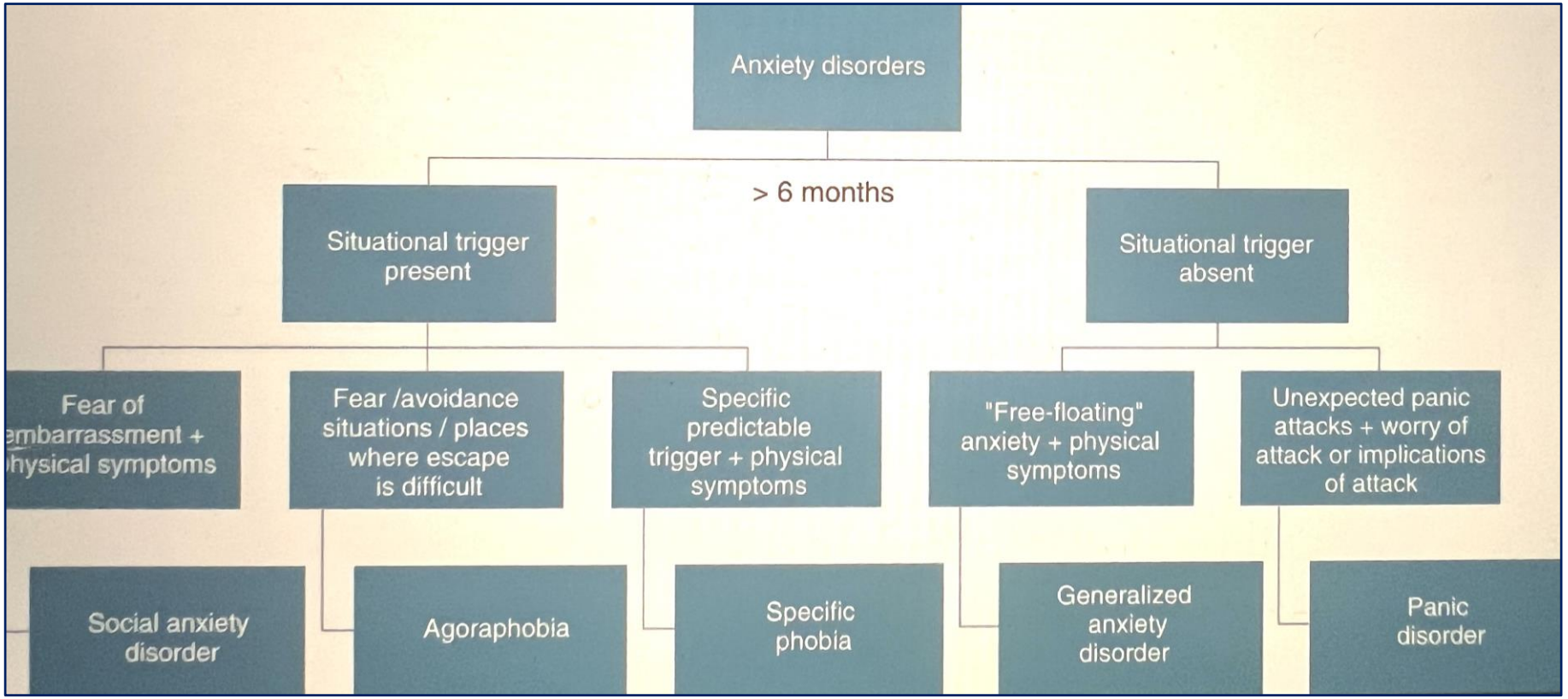
GENERALISED ANXIETY DISORDER

- Your worrying significantly disrupts your job, activities, or social life.
- Your worrying is uncontrollable.
- Your worries are extremely upsetting and stressful.
- You worry about all sorts of things, and tend to expect the worst.
- You've been worrying almost every day for at least six months.

Anxiety Disorders in DSM5

Anxiety Disorders	Obsessive-Compulsive and Related Disorder	Trauma- and Stressor-Related Disorders
• Separation Anxiety Disorder • Selective Mutism • Specific Phobia • Social Anxiety Disorder • Panic Disorder • Agoraphobia • Generalized Anxiety Disorder • Substance/Medication-Induced Anxiety Disorder • Anxiety Disorder Due to Another Medical Condition	• Obsessive-Compulsive Disorder • Body Dysmorphic Disorder • Hoarding Disorder • Trichotillomania (Hair-Pulling Disorder) • Excoriation (Skin-Picking) Disorder • Substance/Medication-Induced Obsessive-Compulsive and Related Disorder • Obsessive-Compulsive and Related Disorder Due to Another Medical Condition	• Reactive Attachment Disorder • Disinhibited Social Engagement Disorder • Posttraumatic Stress Disorder • Acute Stress Disorder • Adjustment Disorders

Diagnostic Algorithm for Anxiety Disorders



Lippincott's Primary Care Psychiatry. Robert M. McCarron, Glen L. Xiong, James A. Bourgeois. Lippincott, William and Wilkens, 2nd Ed. 2018

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Questions about anxiety

Functional Impairment

- Social
  - Withdrawal from family, friends, hobbies
- Occupational
  - Job avoidance
  - Inefficiency
  - Lack of promotion/disciplinary action
- ADLs
  - Inability to
    - Shop for groceries
    - Take a bus
    - Drive a car

Is anxiety/nervousness/worry a problem for you?

Does it change what you do?

How does anxiety change you everyday life?

Have your symptoms ever prevented you from doing something you wanted or needed to do?

What have you given up because of your symptoms?

What triggers your anxiety?

What makes your anxiety better?

Lippincott's Primary Care Psychiatry. Robert M. McCarron, Glen L. Xiong, James A. Bourgeois. Lippincott, William and Wilkens, 2nd Ed. 2018

Benitez C…today ☺

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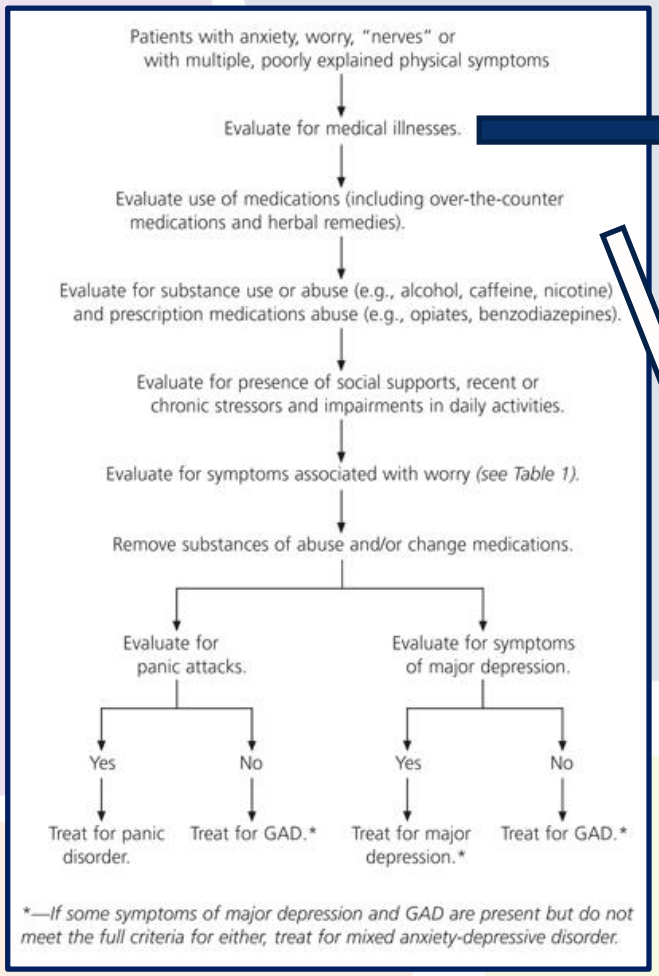
Medical and Substance Abuse Considerations



Anxiety symptoms are the physiologic consequence of another condition

Examples:
Endocrine: Hyperthyroidism, Hypoglycemia, Cushing's
Cardiovascular: CHF, Arrythmia, Pulmonary Embolism
Respiratory: Asthma, COPD, Pneumonia
Metabolic Disturbances: Hypocalcemia, B12 deficiency, Porphyria
Neurological: Seizure Disorder, Dementia, Encephalitis, Neoplasm

Substance Induced Anxiety Symptoms

- Pretty much everything
- Caffeine
- Stimulants
- Alcohol or other CNS Depressants (intoxication or withdrawal)
- Cannabis
- Hallucinogens

Gliatto MF. Generalized Anxiety Disorder. *American Family Physician.* 2000;62(7) 1591-1600

Differentiating Between Anxiety And/Or Depression

	Symptoms more common to anxiety disorders	Symptoms more common to depression	Symptoms common to both anxiety and depression
bodily	• difficulty falling asleep • tremor or palpitations • sweating • hot or cold flushes • faintness, dizziness • muscle tension • nausea • breathlessness	• early morning waking or oversleeping • diurnal variation • chronic or recurrent nagging pain • agitation or slowed behaviour • loss of libido	• sleep disturbance • appetite change • non specific bodily complaints • fatigue • restlessness • headaches • dry mouth
feelings	• depersonalisation • derealisation • helplessness • "stressed out, keyed up" • apprehension	• sadness, despair • guilt, hopelessness • lack of motivation • lack of pleasure, 'flatness' • loss of interest in usual activities, apathy	• irritability • feelings of impending doom, anxious • dependent • loss of enjoyment • tearful • rapid mood swings

Anxiety Disorders: Pearls

- It *is* possible to have more than one anxiety disorder (either co-morbidly or over time)
- Anxiety is common in those with depressive symptoms, but there is also comorbidity with other psychiatric disorders
- Diagnosis of anxiety is based on specific and unique symptoms, triggering events, and timing
- Disability/impairment should be tracked and documented

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Treatment

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Acute Phase Treatment Approach

- Education
  - Tool kits re: diagnosis, course etc. (see resources)
  - Supportive counseling
    - Avoiding excessive caffeine
    - Getting sleep
    - Coping with daily stresses
  - Sleep hygiene
  - Exercise
- Psychotherapy
- Psychopharmacology
- Patient Preference

Culpepper, L. MD,MPH "Use of Algorithms to Treat Anxiety in Primary Care", J Clin Psychiatry 2003;64.

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Non-Pharmacologic Tools

- Cognitive behavioral therapy (CBT)
- Mindfulness-based CBT (MB-CBT)
- Intrapersonal Psychotherapy (IPT)
- Acceptance and Commitment Therapy (ACT)
- Supportive Therapy
- Meditation
- Sleep hygiene
- Exercise
- Diet
- Relaxation and desensitization therapies

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Treatment Innovations

https://lacounty.iprevail.com/

- Free to LA County Residents
- English and Spanish
- Anxiety, Depression, PTSD, among others

Program

- Short assessment
- Self-paced lessons on various topics
- Community support groups
- On-demand coaching by trained peer specialists

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So Many Pharmacologic Tools…

- SSRIs
- SNRIs
- Mirtazapine
- Bupropion
- Buspirone (monotherapy in GAD)
- Trazodone
- Hydroxyzine (*ibid.)*
- Gabapentin, pregabalin, VPA
- Beta blockers (pre-performance)
- TCAs (Imipramine, clomipramine…)
- Benzodiazepines ***with caution***

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First Line

- SSRIs (GAD; PD; SAD)
- SNRIs (GAD; PD; SAD)
  - Especially if comorbid conditions like fibromyalgia
- Buspirone (GAD)
- Beta blocker (performance-only SAD)

Melaragno, AJ. Pharmacotherapy for anxiety disorders: from first-line options to treatment resistance. *Focus* 19.2 (2021): 145-160

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Choosing an SSRI

- What has helped in the past?
- What has helped a family member?
- Is polypharmacy a concern?
- In women of child-bearing age, consider the patient's pregnancy goals/birth control
- Consider potential side effects that could be WELCOME (sedation, increased/decreased appetite, increased energy or activation)

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Second Line

- Other SSRI or SNRIs (GAD; SAD)
- Buspirone (GAD; monotherapy or augmentation)
- Pregabalin (GAD monotherapy or augmentation)
- Benzodiazepines
  - GAD (if no contraindication)
  - PD (high potency e.g. clonazepam)
  - Performance-only SAD (short-acting BZD)

Melaragno, AJ. Pharmacotherapy for anxiety disorders: from first-line options to treatment resistance. *Focus* 19.2 (2021): 145-160

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Third Line

- TCAs (GAD; PD; tolerability and safety)
- Quetiapine (GAD; mono or aug; metab effects)
- Mirtazapine (PD; efficacy and tolerance)
- BZD (SAD; partial response to SSRI)

Melaragno, AJ. Pharmacotherapy for anxiety disorders: from first-line options to treatment resistance. *Focus* 19.2 (2021): 145-160

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Fourth/Fifth Line

- Augmentation with Second Gen Antipsychotics (GAD; PD)
- Miscellaneous antidepressants (GAD; limited data and adverse effects)
- MAOi's (PD; SAD; adverse effects)
- VPA (PD; SAD; mixed results)
- Mirtazapine (SAD)
- SGAs

Melaragno, AJ. Pharmacotherapy for anxiety disorders: from first-line options to treatment resistance. *Focus* 19.2 (2021): 145-160

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Generalized Anxiety Disorder Treatment

- SSRIs/SNRIs again are FIRST LINE treatment
  - Benzodiazepines MAY have a role but
    - Temporary e.g. during initiation of SSRIs/SNRIs – AVOID long term benzo use!
- Buspirone: Start 5-10mg BID, then increase gradually, max 60mg/day
- Propranolol, clonidine: both low dosage multiple times a day to help with physical symptoms of anxiety
- Hydroxyzine 10-50mg Q6h prn(significant anticholinergic effects at high doses)
- Gabapentin 300-900mg TID
- Pregabalin
- Psychotherapy
- Behavioral changes – exercise, breathing techniques, sleep hygiene
- Relationship

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OCD Treatment

- High dose SSRIs in general, or clomipramine
- Can be very complicated to treat – most likely will need a referral out, and may need augmentation with antipsychotics
- Compulsive behaviors may be responsive to CBT, but obsessions are less responsive

PTSD Treatment

- Pharmacotherapy
  - Antidepressants (Fluoxetine 40mg/day, Sertraline 100-200mg/day, Paroxetine 20-40mg/day, and other SSRIs).
  - No indication for Benzodiazepines, unless adjunctive (for hyper-arousal)
  - Mood Stabilizers – usually same doses used to treat bipolar disorder
  - Second generation Antipsychotics - combined with SSRI
  - Prazosin 1-10mg QHS, for nightmares associated with PTSD
- Psychotherapy
  - CBT
  - Supportive therapy (individual or group)
  - Eye movement and reprocessing

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Treatment Pearls

- Find good strategies for patient education about condition/course and important concepts
  - Reassurance
  - Rate of change over time
  - Perception of relief/change
  - Goal of treatment is not absence of any anxiety
- Don’t underestimate additive effects of small changes
- Medications and psychotherapy may be equally effective
- If you use medications, ***start*** low and go slow
  - Most common mistake by PCP’s is dosing too low
  - And don’t give up too early
- Change management/ Motivational Interviewing
- Monitor change

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SSRIs with Fewer Drug-Drug Interactions

- **Sertraline** (Zoloft) – start 12.5-50mg daily, titrate to 100-200mg daily
- **Citalopram** (Celexa) – start 10-20mg, titrate up to 40mg daily
- **Escitalopram** (Lexapro) – theoretically fewer side effects than citalopram; start at 5-10mg daily, titrate up to 20mg daily
- Adjust dose timing according to individually experienced side effects:
  - Sedation vs activation/insomnia
  - Nausea

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Other Commonly Used SSRIs

- **Fluoxetine** (Prozac) – half-life of approximately 1 week: start at 10-20mg, titrate up to 80mg/day max. Usual effective dose is between 40-60mg.
  - Easy to d/c medication due to long half-life, fewer withdrawal effects
  - Good for patients who sometimes miss medication doses
  - More drug-drug interactions
- **Paroxetine** (Paxil) – very short half-life (approximately 12 hours, longer with higher doses); start 10mg QHS (usually), and titrate up to 50mg daily max.
  - Very anticholinergic and sedating, making BID dosing difficult for some patients to tolerate

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SNRIs

- **Venlafaxine** (Effexor XR) – mildly increases BP, relatively short half-life; start at 37.5mg, titrate up to 375mg daily max
  - Frightening withdrawal syndrome if dose is missed (not dangerous)
  - Tends to be activating, gives jitters initially, patients may need to avoid caffeine
- **Duloxetine** (Cymbalta) – generally no increase in BP; FDA approved for pain syndromes; start 30mg daily, titrate up to 120mg daily (can split doses, and 60mg daily may be effective).
- **Desvenlafaxine** (Pristiq) – derivative of venlafaxine; good for menopausal symptoms when dosed at 50mg/day. Similar side effect profile to venlafaxine. May not be covered by Medi-Cal without prior authorization

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Other Antidepressants

- **Bupropion** (Welbutrin) – dosing depends on formulation, titrate to 450mg max daily.
- 3 Forms:
  - IR – requires TID dosing, most seizure risk
  - SR – BID dosing
  - XL – once daily dosing, fewer reported side effects, smallest seizure risk. Effective dose is 150-300mg daily. Rarely need to increase to 450mg daily.
- Side Effects: NO SEXUAL SIDE EFFECTS; increases anxiety and irritability, may increase BP, tends to be activating, and carries seizure risk, so do not use in seizure disorder or during an active eating disorder.

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Other Antidepressants

- **Mirtazapine** (Remeron) – start at 7.5mg -15mg QHS, titrate to max of 45mg daily.
  - Tetracyclic antidepressant, with most activity at Serotonin and Norepinephrine receptors
  - Very sedating at low doses (30mg or less)
  - Orthostatic hypotention is possible
  - Norepinephrine activity is more apparent at higher doses, and reduces sedating effect
  - High weight gain potential (with associated metabolic sequelae)
  - Few drug-drug interactions
  - Minimal sexual side effects
  - Off label uses for anxiety disorders, nausea, and at low doses, insomnia

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Other Antidepressants

- **Vortioxetine** (Brintellix) – Approved by FDA in 2013 for MDD, no generic available yet
- SSRI
  - Antagonizes 5-HT3 receptors, but agonizes 5-HT1A and 5-HT7: helps with cognitive function
  - Some reports say fewer sexual side effects than other SSRIs, otherwise similar side effect profile, nausea is most common
  - Weight neutral
  - Very long half-life (57 hours)
  - Start at 5-10mg daily, effective dose ranges between 10-20mg daily.

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Other Antidepressants: Tricyclics

- **Amitriptyline, Nortriptyline, Desipramine, Imipramine, Clomipramine**
  - Not used as first line, due to high lethality in overdose, more side effects
  - Off label uses include Headaches, insomnia, nerve pain in diabetes and fibromyalgia, and urinary incontinence
  - Anticholinergic side effects are problematic, can lead to confusion and delirium in the elderly if not monitored closely
  - Cardiac risks: those over 65 and/or h/o heart disease need pre-treatment EKG and at least yearly monitoring. Those with arrhythmias or recent MI should NOT be given tricyclics
  - Seizure risk

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Antidepressants: Patient Education

- **Discuss medication compliance**: once the patient figures out the right time of day to take the medication based on their side effects, take at the same time EVERY DAY
- **Discuss realistic expectations**:
  - **Everything has side effects!** Most side effects from antidepressants fade within 2 weeks of starting the medication, though may temporarily reappear with increased doses
    - **How long do they take to work?** May see some results in 2 weeks at adequate dose, though likely not for 4 -6 weeks. Follow up every 2-4 weeks (phone is OK) until dose is stabilized. Switch if intolerable adverse effects or no effect at adequate dose after 4-6 weeks.
  - **How long to treat?** At least a year after positive effect is seen, then can consider weaning off medication
  - **Risk of relapse** is 50% with first episode of depression, 70% after two episodes of depression and 90% after three episodes of depression

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Acute Phase Treatment Approach

- Follow-up and outreach
  - Pt concerns
  - Adherence
  - SE's
- Treatment Response

Culpepper, L. MD,MPH "Use of Algorithms to Treat Anxiety in Primary Care", J Clin Psychiatry 2003;64.

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Benzodiazepines

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Benzodiazepine Pearls

- Avoid long term benzodiazepine use
  - They can be helpful in certain situations ***if*** they are managed
    - Panic attacks
    - Managing side effects or symptoms during titration
- Management strategies
  - Describe what to expect/goals of treatment
  - Discuss risks
  - Set expectations for length of treatment

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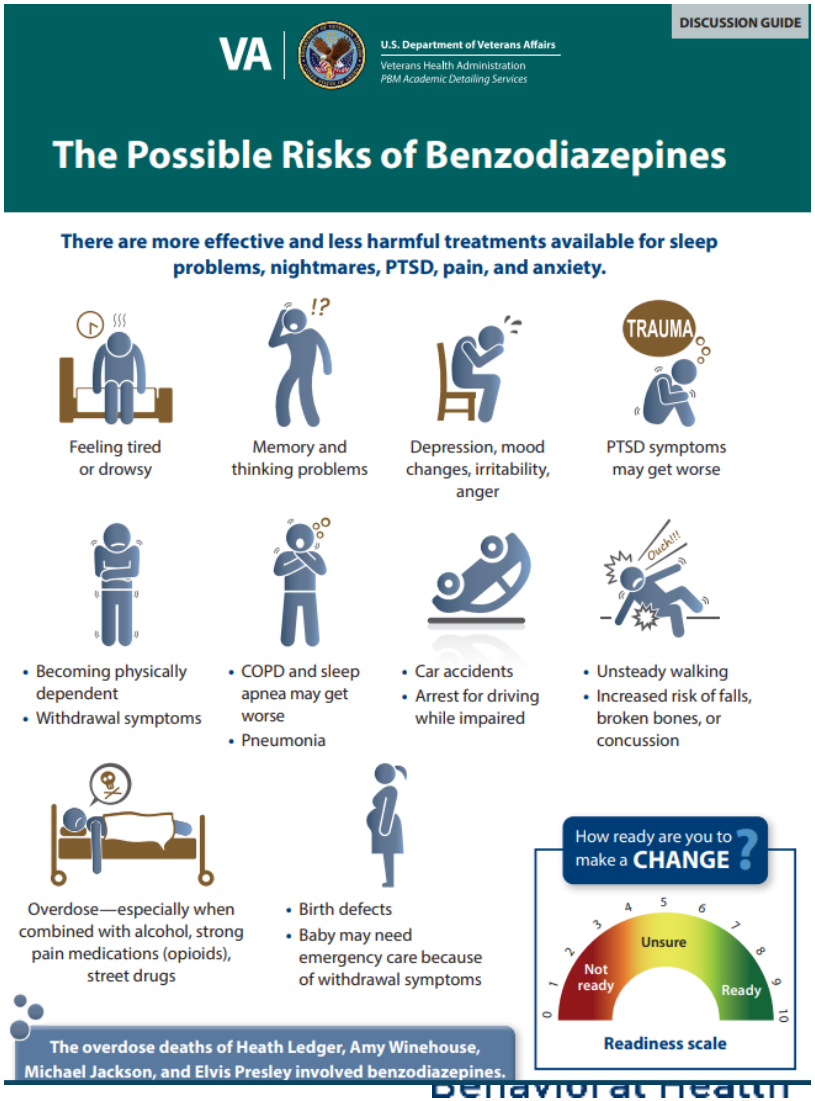
Benzodiazepine Management Strategies

When to Avoid Benzo Use

- Treatment non-participation
  - e.g. missing appointments, not taking other treatments
- Losing or "losing" their meds
- Psychiatric management elsewhere
- Risk of cognitive impairment
- Severe liver disease
  - Not prohibitive… choose "LOT" Lorazepam

Discuss

- Goals of use
- What to expect
- Length of treatment



Benzodiazepines in Panic Disorder

Benzodiazepine	Advantages	Disadvantages
Alprazolam* Lorazepam	Rapid onset of action, most useful for initial stages of panic disorder treatment Good tolerance Efficacy against anticipatory anxiety	Higher doses required than those effective for GAD Dose-related Sedation Risk of tolerance and dependence Interdose rebound rxn Need for multiple daily doses
Clonazepam	Can be more easily discontinued, compared with shorter-acting benzodiazepines	Slow onset of antipanic action Risk of treatment-emergent depression

Principles and Practice of Psychopharmacolotherapy, Janicak, et al.

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Treatment of Anxiety Disorders:

Benzodiazepine alternatives

- Hydroxyzine 10mg-50mg TID-QID prn anxiety
  - FDA approved, but very sedating
- Gabapentin
  - 300mg-900mg TID, can cause significant GI distress
- Pregabalin
- Buspirone 20-30mg divided BID or TID
  - FDA approved for GAD, but not immediately acting
- Trazodone 25mg-300mg QHS prn insomnia
- Benadryl 25mg-50mg QHS prn insomnia

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What if a patient is already on benzodiazepines?

Steps and Strategies to Help with Discontinuation

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Discussing benzodiazepine discontinuation

1 Assess patient's willingness to discontinue or reduce the dose.

Action	Provider response
Express concern	*"I would like to take a minute to discuss my concerns about (benzodiazepine name)."*
Provide education on potential risks	*"Because of your [age or other risk factors], I am concerned that the use of (benzodiazepine name) may put you at increased risk for [relevant repercussion]."*
Assess patient's readiness to begin taper process	*"What do you see as the possible benefits of stopping or reducing the dose? What concerns do you have about stopping? What can we do together to help address these concerns?"* If patient indicates no desire to change, provide information handout. *"What would be a reason you might consider changing from (benzodiazepine name) to (name of recommended alternative)?"*
Negotiate plan	*"What changes are you willing to make to meet this goal?"* *"Would you be willing to talk to one of my colleagues to learn about options to support your changes?"*

https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/10-1526_Benzos_Provider_PossibleRisksofBenzos_P97046.pdf

2 Agree on timing and discuss symptoms that can occur with benzodiazepine taper.

Inform patients:

- Symptoms of withdrawal are only temporary.
- Slowly tapering can decrease withdrawal symptoms.
- If distressing symptoms are experienced, the taper can be adjusted.

https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/10-1526_Benzos_Provider_PossibleRisksofBenzos_P97046.pdf

3 Provide written instructions for a structured medication taper. Be prepared to slow the taper if the patient reports significant withdrawal symptoms.

SHORTER TAPER

- Gradually reduce total dose by 50% over the first 4 weeks (e.g., 10–15% decrease weekly)
- Maintain on that dose (50% original dose) 1–2 months, *then*
- Reduce dose by 25% every 2 weeks

LONGER TAPER

- 10–25% every 2-4 weeks

Tips for tapering

- Begin the taper with the benzodiazepine prescribed.
- If a patient is unable to tolerate tapering a shorter-acting medication, switch to a long-acting option (e.g., diazepam for younger adults, lorazepam for adults age 65 and over).
- A slower or longer taper schedule is recommended in most cases.
- The rate of benzodiazepine taper should ultimately be determined by the patient's symptoms.

For a taper calculator and other resources, go to https://dvagov.sharepoint.com/sites/vhaacademicdetailing

https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/10-1526_Benzos_Provider_PossibleRisksofBenzos_P97046.pdf

Benzodiazepine withdrawal symptoms and non-drug ways to address[7,14-18]

Insomnia, nightmares, sleep disturbances

- Reviewing sleep hygiene (e.g., avoiding tea, coffee, stimulants or alcohol around bedtime)
- Relaxation tapes, anxiety management techniques
- Exercise
- Schedule most of the benzodiazepine dose at night during the taper period

Anxiety symptoms and panic attacks

- Psychological techniques
  - Individual or group behavior therapy
  - Cognitive behavioral therapy
- Physical activity (e.g., aerobics, walking, swimming)
- Yoga
- Meditation
- Acupuncture

https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/508/10-1526_Benzos_Provider_PossibleRisksofBenzos_P97046.pdf

Long-Term Treatment for Anxiety Disorders

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Long Term Treatment Approach

- Goal ≠ Response
- Goal = remission and full functional return.
- Use of screening measures or tracking troublesome symptoms over time
- Monitor other common obstacles
  - Adherence
  - Side effects (late SE's of serotonergic drugs, weight)
- Education about risks, relapse, etc.

Culpepper, L. MD,MPH "Use of Algorithms to Treat Anxiety in Primary Care", J Clin Psychiatry 2003;64.

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Treatment Discontinuation

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Pearls

- Full recovery from anxiety disorders may occur
- But anxiety disorders can be chronic, with periods of remission and recurrence
  - The “art” of medicine

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Useful Resources for Patients and Families

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National Institute of Mental Health

Transforming the understanding and treatment of mental illnesses.

Search the NIMH website | Search

Información en español

Celebrating 75 Years! Learn More >>

MENTAL HEALTH INFORMATION | GET INVOLVED | RESEARCH | FUNDING | NEWS & EVENTS | ABOUT US

Health Topics

NIMH offers expert-reviewed information on mental disorders and a range of topics.

Statistics

NIMH statistics pages include statistics on the prevalence, treatment, and costs of mental illness for the population of the United States.

Brochures and Fact Sheets

Download, read, and order free NIMH brochures and fact sheets about mental disorders and related topics.

Help for Mental Illnesses

If you or someone you know has a mental illness, there are ways to get help. Use these resources to find help for yourself, a friend, or a family member.

Clinical Trials

If you or a friend or family member are thinking about taking part in clinical research, this page contains basic information about clinical trials.

It is not the intention of NIMH to provide specific medical advice, but rather to provide users with information to better understand their health and their diagnosed disorders. Consult with a qualified health care provider for diagnosis, treatment, and answers to your personal questions.

Please Note: Links to other websites are provided for informational purposes only and do not constitute an endorsement by NIMH.

Mental Disorders and Related Topics

- Anxiety Disorders

Science News

Researchers Solve the Puzzle of a Brain Receptor's Activation

Mothers' Difficult Childhoods Impact Their Children's Mental Health

Newly Discovered Brain Connection Affects Reward Behavior in Mice

https://www.nimh.nih.gov/health/topic

Local Mental Health Hotlines

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

ABOUT DMH | OUR SERVICES | FOR PROVIDERS

GET HELP NOW!

If you or a loved one is experiencing or affected by a mental health, substance use, or suicidal crisis, please call or text ***'988'*** *(or chat online on 988 Suicide & Crisis Lifeline's website) for free, confidential, and immediate help. (Learn more about the recently launched 988 Lifeline.)*

FOR MENTAL HEALTH RESOURCES AND SUPPORT, PLEASE CALL OUR 24/7 HELP LINE AT (800) 854-7771

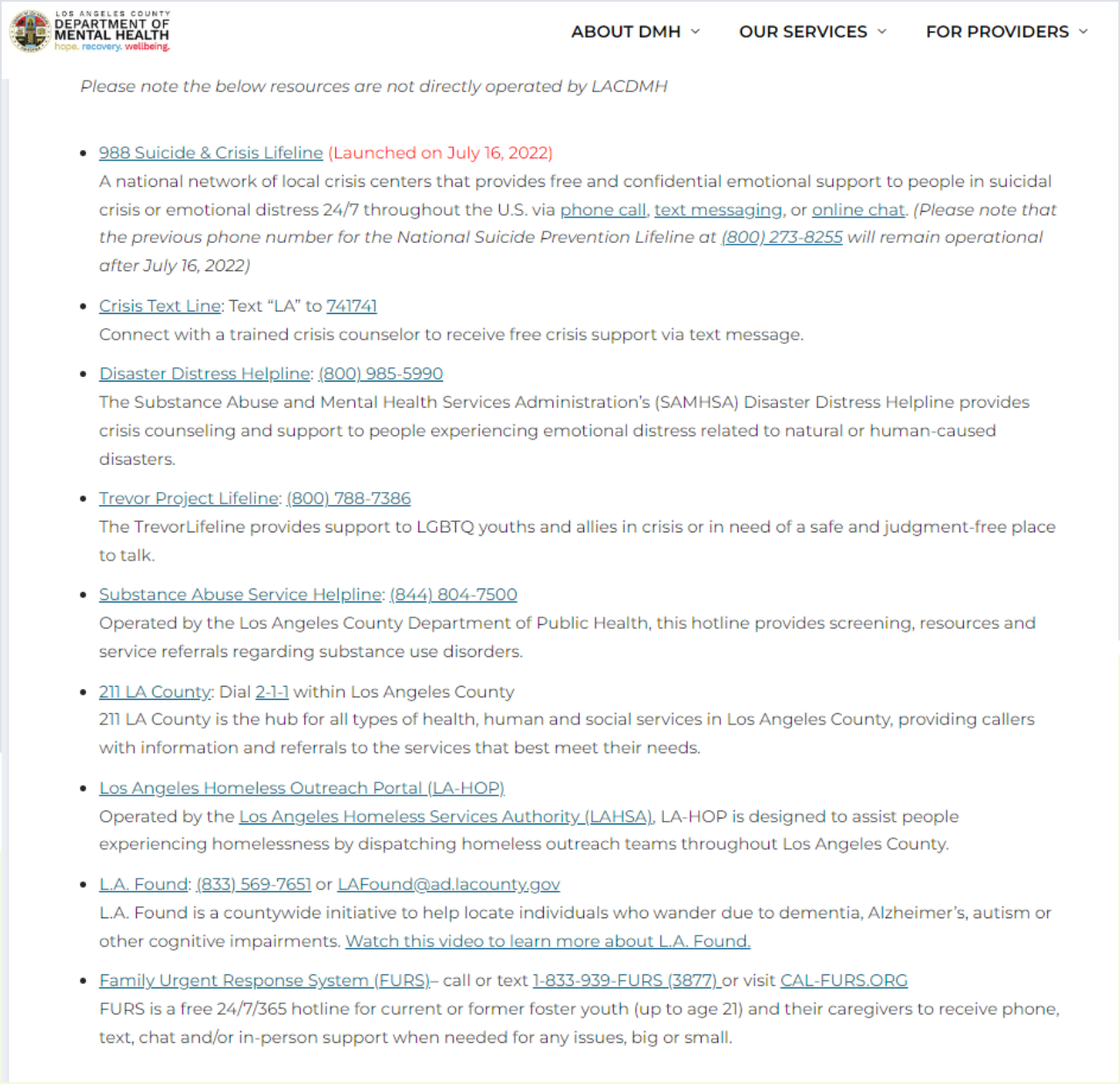
The LACDMH Help Line serves as the primary entry point for mental health services with our department; services provided by our Help Line staff include:

- **Access Line** for Service Referrals, Crisis Assessments and Field Deployments – available 24/7 (**option 1** when calling the Help Line)
  - Mental health screening and assessment
  - Referral to a service provider
  - Crisis counseling
  - Mobilizing field response teams
  - Linkages to other services and resources
- **Emotional Support Warm Line** with Trained Active Listeners – available 10:30 a.m. to 9 p.m. daily (**option 2** when calling the Help Line)
- **Veteran Line** for Mental Health Support and Connection to Veteran Programs – available 9 a.m. to 8 p.m. daily (**option 3** when calling the Help Line)

Those with hearing or speech disabilities may use their preferred relay service or call 711 to connect with our Help Line. With 711, *please ask the operator – who will serve as the interpreter between the caller and our staff – to call our Help Line at (800) 854-7771. For additional resources to help those living with disabilities, refer to this resource guide developed by our Access for All UsCC.*

Help us spread the word about this important resource. View/download our Help Line toolkit here.

Local Mental Health Hotlines



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ABOUT DMH | OUR SERVICES | FOR PROVIDERS

Please note the below resources are not directly operated by LACDMH

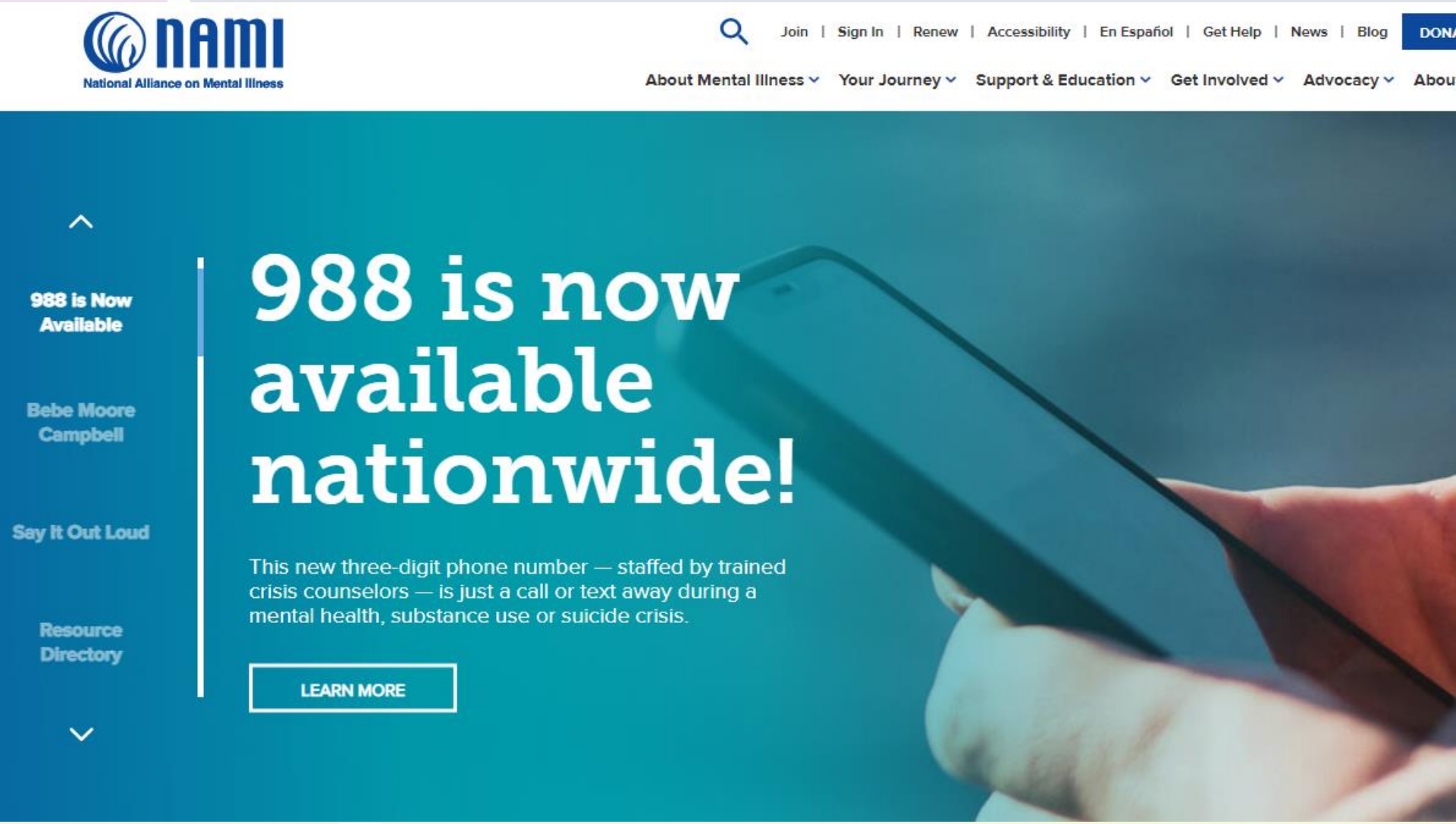
- 988 Suicide & Crisis Lifeline (Launched on July 16, 2022)
  A national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24/7 throughout the U.S. via phone call, text messaging, or online chat. *(Please note that the previous phone number for the National Suicide Prevention Lifeline at (800) 273-8255 will remain operational after July 16, 2022)*
- Crisis Text Line: Text "LA" to 741741
  Connect with a trained crisis counselor to receive free crisis support via text message.
- Disaster Distress Helpline: (800) 985-5990
  The Substance Abuse and Mental Health Services Administration's (SAMHSA) Disaster Distress Helpline provides crisis counseling and support to people experiencing emotional distress related to natural or human-caused disasters.
- Trevor Project Lifeline: (800) 788-7386
  The TrevorLifeline provides support to LGBTQ youths and allies in crisis or in need of a safe and judgment-free place to talk.
- Substance Abuse Service Helpline: (844) 804-7500
  Operated by the Los Angeles County Department of Public Health, this hotline provides screening, resources and service referrals regarding substance use disorders.
- 211 LA County: Dial 2-1-1 within Los Angeles County
  211 LA County is the hub for all types of health, human and social services in Los Angeles County, providing callers with information and referrals to the services that best meet their needs.
- Los Angeles Homeless Outreach Portal (LA-HOP)
  Operated by the Los Angeles Homeless Services Authority (LAHSA), LA-HOP is designed to assist people experiencing homelessness by dispatching homeless outreach teams throughout Los Angeles County.
- L.A. Found: (833) 569-7651 or LAFound@ad.lacounty.gov
  L.A. Found is a countywide initiative to help locate individuals who wander due to dementia, Alzheimer's, autism or other cognitive impairments. Watch this video to learn more about L.A. Found.
- Family Urgent Response System (FURS)– call or text 1-833-939-FURS (3877) or visit CAL-FURS.ORG
  FURS is a free 24/7/365 hotline for current or former foster youth (up to age 21) and their caregivers to receive phone, text, chat and/or in-person support when needed for any issues, big or small.

https://dmh.lacounty.gov/get-help-now/

Crisis Hotlines

Health hotlines

- **988 Suicide & Crisis Lifeline**: The Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week, across the United States. Call or text **988** to connect with a trained crisis counselor. Support is also available via live chat at **988lifeline.org**. Para ayuda **en español, llame al 988**.
- **Disaster Distress Helpline**: People affected by any disaster or tragedy can call this helpline, sponsored by SAMHSA, to receive immediate counseling. Call or text **1-800-985-5990** to connect with a trained professional from the closest crisis counseling center within the network.
- **Veterans Crisis Line**: This helpline is a free, confidential resource for veterans of all ages and circumstances. Call **1-800-273-8255** and press 1, text **838255**, or **chat online** to connect with 24/7 support.



https://www.nami.org/Home

Frequently Asked Questions (FAQs)

1. True or False: The presence of anxiety symptoms or complaints about anxiety symptoms are always due to an anxiety disorder that warrants treatment.

False. Anxiety symptoms are common in clinical encounters, but they do not always represent anxiety disorders that warrant treatment. Anxiety symptoms can be normative responses to stressors, manifestations of other conditions including medical illness, and can vary over time. Conversely, some patients with anxiety disorders minimize psychiatric complaints and present with primarily somatic concerns. Primary Care Providers (PCPs) should be vigilant for common presentations that involve anxiety and be prepared to evaluate patients accordingly.

2. What treatments can be used to treat anxiety disorders?

In general, multiple treatment modalities have proven successful for the treatment for anxiety disorders. Available treatments include medications, psychotherapy, combinations of both, and other forms of intervention. Choice of treatment can be based on history, patient preference, and symptom severity.

FAQs

3. Should PCPs assess patients with anxiety disorders for risk of self-harm/suicide?

PCPs should ask patients, including those with anxiety disorders, about suicidal thoughts, intent, or plans. Patients with anxiety disorders are at elevated risk for suicide. Asking about suicidal thoughts does not increase the risk of suicide. Reducing access to lethal means, especially firearms, can reduce suicide risk.

4. When should PCPs consult mental health professionals regarding diagnosis of anxiety?

Psychiatric consultation is recommended for comorbid psychiatric conditions, severe impairment and symptoms, heightened suicide risk, or lack of response to appropriate treatment.

Q & A Session

Thank you!

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