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The Mental Health Clinical Advisory Group

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Introduction

The [Mental Health Clinical Advisory Group \(MHCAG\)](#) was established in the Oregon Health Authority (OHA) by the Oregon Legislature in 2017. According to Oregon statute [ORS 414.359](#), MHCAG must develop evidence-based treatment algorithms and guidance for Oregon providers, including treatment with mental health drugs.

According to statute, the MHCAG treatment recommendations must be based on:

- The efficacy and safety of treatment
- Patient-specific considerations; and
- Cost of treatment.

The MHCAG may also provide recommendations to OHA and the Oregon Pharmacy & Therapeutics Committee on:

- Implementation of evidence-based treatment guidance for OHA's Medicaid program;
- The [preferred drug list](#) (PDL) of mental health drugs used by the OHA's fee-for-service Medicaid program;
- Coordinating with the [Oregon Psychiatric Access Line](#) (OPAL) at Oregon Health & Science University, which is available to Oregon providers who prescribe mental health drugs.

Composition

The MHCAG consists of 18 members appointed by OHA as defined by [ORS 414.359](#). Members of MHCAG represent several groups that care and advocate for individuals with mental disorders (see **Table 1**). All published recommendations are approved by consensus vote of members.

Table 1. MHCAG Member Representation (number)

Psychiatrists (2)
Child/Adolescent Psychiatrist (2)
Clinical Psychologists (2)
Psychiatric Nurse Practitioner (1)
Primary Care Physicians (2)
Pharmacists (2)
Mental health advocacy organizations (2)
Coordinated care organizations (2)
Consumer of mental health services (1)
Federally Recognized Oregon Indian Tribe (1 (open))

Department of Corrections (1)

Research Methods

The MHCAG adopted research methods in 2021 that emphasize high quality evidence and follows the standard hierarchy of evidence, prioritizing systematic reviews and randomized clinical trials before observational studies and non-controlled studies. The [MHCAG research methods](#) are available on the MHCAG website and include the tools used to grade the quality of systematic reviews and clinical practice guidelines, as well as assess biases and applicability of clinical trials.

Clinical Practice Recommendations

The MHCAG continues to develop treatment algorithms and other clinical practice recommendations and resources for clinicians and patients. All documents are available on the website under [MHCAG Recommendations and Resources](#). Below are brief summaries that highlight a small sample of the recommendations previously published. Interested readers are encouraged to read each document for more detail and to explore all the published documents on the website. The recommended non-pharmacological and pharmacological treatments are covered under Oregon's Medicaid program, most without requirement of prior authorization.

Table 2. Schizophrenia

Link: Treatment with Antipsychotic Medications
All antipsychotics are effective for schizophrenia
Clozapine is the most effective antipsychotic medication
Choice of an antipsychotic should depend on: <ul style="list-style-type: none">• Side effect profile• Availability of a long-acting formulation
Long-acting formulations: <ul style="list-style-type: none">• Include aripiprazole, risperidone and paliperidone• Reduce risk of hospitalization and relapse• Offer convenience• Help providers assess adherence• Use a trauma-informed approach to care in patients with history of trauma or coercive injection of antipsychotics.
Offer clozapine to patients who do not respond to adequate trials of two different antipsychotics

Table 3. Bipolar Disorder

Link: Treating Acute Bipolar Depression
Offer each patient a psychosocial treatment and first-line medication:
<ul style="list-style-type: none"> • Lamotrigine • Lithium • Quetiapine
Second-line options: cariprazine, divalproex or lurasidone
Combination therapy (commonly with lamotrigine)
Avoid antidepressant monotherapy
Link: Treating Acute Bipolar Mania
Offer each patient a psychosocial treatment and first-line combination medication therapy:
<ul style="list-style-type: none"> • Quetiapine and lithium • Quetiapine and divalproex
Second-line monotherapy options: aripiprazole, asenapine, cariprazine, risperidone, ziprasidone
Consider clozapine for severe symptoms (as always, providers can utilize OPAL for treatment help)
Avoid lamotrigine for treatment of acute mania only

Table 4. Tapering Benzodiazepines

Link: How to Approach a Benzodiazepine Taper
The provider must establish realistic expectations with themselves and the patient
Create a plan to manage anxiety symptoms
Taper the benzodiazepine using the following approach:
<ul style="list-style-type: none"> • Individualized (no 'one-size-fits-all' approach) • Slow (with possible pauses in taper)
Rate of taper depends on:
<ul style="list-style-type: none"> • Severity of withdrawal symptoms • Original dose, type, potency, duration of action, and length of use of benzodiazepine • Reason the benzodiazepine was originally prescribed • Personality and vulnerability of the patient, their lifestyle, personal stresses and social support
Most patients will benefit by switching to diazepam before tapering

Table 5. Generalized Anxiety Disorder

Link: Treating Adults with Generalized Anxiety Disorder
Offer psychosocial treatment and a first-line medication:
<ul style="list-style-type: none"> • Escitalopram • Sertraline • Duloxetine • Venlafaxine (extended release)
Adjunctive therapy:
<ul style="list-style-type: none"> • First-line adjunct: pregabalin • Second-line adjunct: buspirone

Benzodiazepines like diazepam or lorazepam can provide short-term relief of severe somatic symptoms

Table 6. Insomnia Disorder

Link: Treating Insomnia Disorder
Due diligence is recommended to figure out why a patient has disordered sleep; address modifiable causes
Goal is to achieve restorative sleep, not simply to reduce latency to sleep onset
Sleep disturbances are commonly reported in menopausal transition
Offering sleep hygiene recommendations alone is not effective
Use a harm reduction approach for treating insomnia disorder:
<ul style="list-style-type: none"> • Cognitive behavioral therapy for insomnia (CBT-I) • Online CBT-I programs and mobile apps • Limit medication to 4 weeks only after CBT-I has been tried: <ul style="list-style-type: none"> ○ Doxepin ○ Trazodone ○ Lemborexant ○ Suvorexant ○ Eszopiclone ○ Zolpidem

Table 7. Post-Traumatic Stress Disorder (PTSD)

Link: Treating PTSD
Use a trauma informed approach to care (Trauma Informed Oregon)
Perform safety, lethal means, and environmental assessment
Complex PTSD may be a distinct disorder from PTSD and borderline personality disorder
Do not delay PTSD treatment in patients with co-occurring mental health or substance use disorders
Psychotherapy: <ul style="list-style-type: none"> • Trauma-focused cognitive behavioral therapy • Cognitive processing therapy • Eye movement desensitization reprocessing • Prolonged exposure therapy
Pharmacotherapy (adults): <ul style="list-style-type: none"> • Paroxetine • Sertraline • Venlafaxine (extended release) • Prazosin (for nightmares)
Avoid starting benzodiazepines. Benzodiazepines: <ul style="list-style-type: none"> • Are ineffective at preventing or treating PTSD, • Reduce the effectiveness of trauma-specific psychotherapy, and • Have high potential for abuse and patient harm

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