ECHO IDAHO

Behavioral Health in Primary Care

Clinical Pearls

9/16/26

Stephen Carlson, PharmD

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Project ECHO

Learning Objectives

- Deprescribing is a reasonable course of action avoid medication cascades
- Have an expectation conversation regarding starting a new medication
- Utilize resources such as the National Maternal Mental Health Hotline, CredibleMeds.org, and Idaho Prescription Monitoring Program

Deprescribing is always and option

- Verifly your clinical diagnosis matches all current medications
- Remove any Beers listed medications if possible
- Avoid if possible, causing a medication cascade of adding additional medication to treat side effects

Expectation conversations

- Have an expectation conversation with all new patients or reestablish expectations with current patients when starting a new medication

- Explain the whys of your selection and that you expect them to give you feedback about what you don't like about a specific medication and that we might have other options

Utilize Resources

- Utilize resources such as the National Maternal Mental Health Hotline, CredibleMeds.org, and Idaho Prescription Monitoring Program
- Assessing risk of drugs that prolong the QT interval and cause arrhythmias
  - https://crediblemeds.org
- Prescription Monitoring Program
  - https://idaho.pmpaware.net

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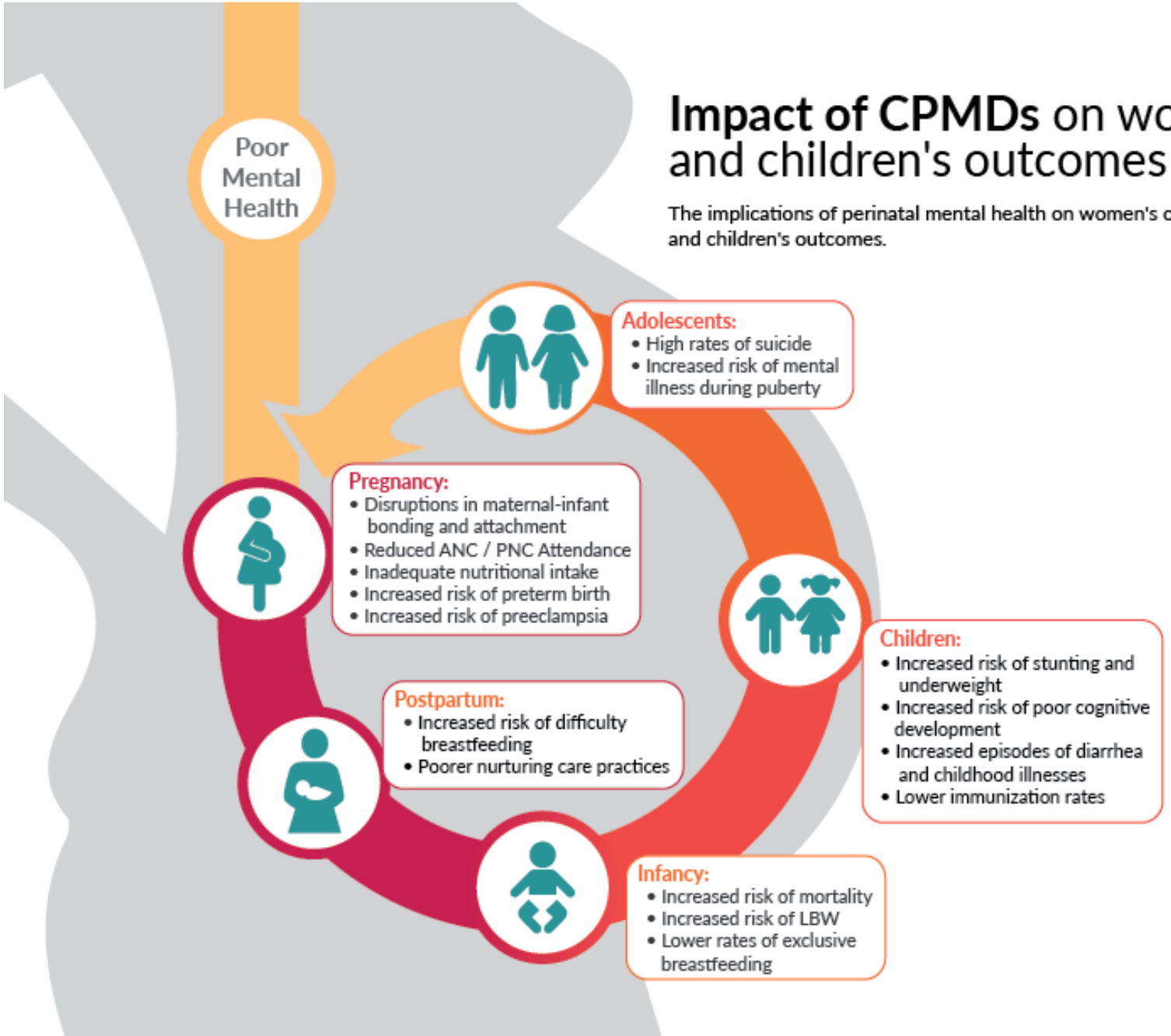
Project ECHO

Learning Objectives

- Review clinical pearls related to perinatal mental health
- Discuss how to integrate the three C's into clinical practice

Impact of CPMDs on women and children's outcomes

The implications of perinatal mental health on women's outcomes and children's outcomes.



Screening

- Who can screen?
  - ALL providers who interface with pregnant or postpartum women
- Recommended screening schedule
  - First prenatal visit
  - At least once in second trimester
  - Six-week postpartum obstetrical visit (or at first postpartum visit)
  - Repeated screening at 6 and/or 12 months in OB and primary care settings
  - 1, 2, 4, 6-month pediatric visits

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Treatment Considerations

Clinical guidelines/best practices for supporting medication usage

- Psychoeducation and interdisciplinary collaboration are key
- Maximize non-pharmacological interventions as a first line defense when possible
- If patient becomes pregnant while on medications, DO NOT encourage discontinuation or change in meds if medication is effective and patient is well
- Risk vs reward model
- Most critical window is between 36 weeks GA and 4 weeks postpartum
- DO NOT taper off medications as delivery approaches
- Rapid drop in Estrogen within first 48 hours after birth results in a dramatic drop in Serotonin levels and an increase in Dopamine
- Encourage patients to take their medications as prescribed to increase efficacy and decrease double exposure

The Three C's

- Collaboration
- Compassion
- Curiosity

Resources

- Massachusetts General Hospital Center for Women's Mental Health
  - https://womensmentalhealth.org
- National Maternal Mental Health Hotline
  - 1-833-TLC-MAMA
- Postpartum Support International
  - Toll-free helpline for women and families 1-800-944-4773
  - Perinatal Psychiatric Consult Line 1-800-944-4773
    - Medical providers only
  - www.postpartum.net
- Local Resources
  - PSI Idaho chapter
  - Idaho Infant and Toddler program
  - Idaho Parents Unlimited
  - Parents as Teachers
  - Nurse-Family Partnership
  - St. Lukes
  - St. Alphonsus

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https://www.mmhla.org/fact-sheets

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Don't Pathologize Grief or Culture

- Grief is messy and doesn't always abide by the medical model
- Be mindful of cultural or spiritual understandings that might be different than your own
- Let compassion and curiosity be your guide as you apply care to your grieving patient

Defining Faith Deconstruction

"The process of questioning, re-examining, and critically analyzing beliefs and values within a faith tradition, often leading to a reevaluation or even a shift away from those beliefs."

- Two types of Faith Deconstruction (*Swoboda*)
  - Soft (intellectual repentance)
  - Hard (faith abandonment/deconversion)

Why do people deconstruct?

Why would anyone want to do this!?

- Seeking authenticity: asking why do I believe what I believe?
- Dealing with doubt: grappling with questions?
- Responding to harm: reacting to negative experiences, hypocrisy
- Spiritual burnout: feeling as if the faith is fading

What is EMDR?

- Eye Movement Desensitization Reprocessing
- *Evidence-based psychotherapy approach
- The goal of EMDR: facilitate adaptive information processing (AIP)
- Uses 8 structured phases to accomplish AIP

What is AIP?

- Adaptive Information Processing
- The human brain wants to heal and can heal
  - Some memories are not fully processed and not functionally stored
- What does it mean to “process” a memory?

Safety Planning tasks

The Safety Plan Intervention involves more tasks than simply completing the Safety Plan Form

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Substance Abuse and Mental Health Services Administration

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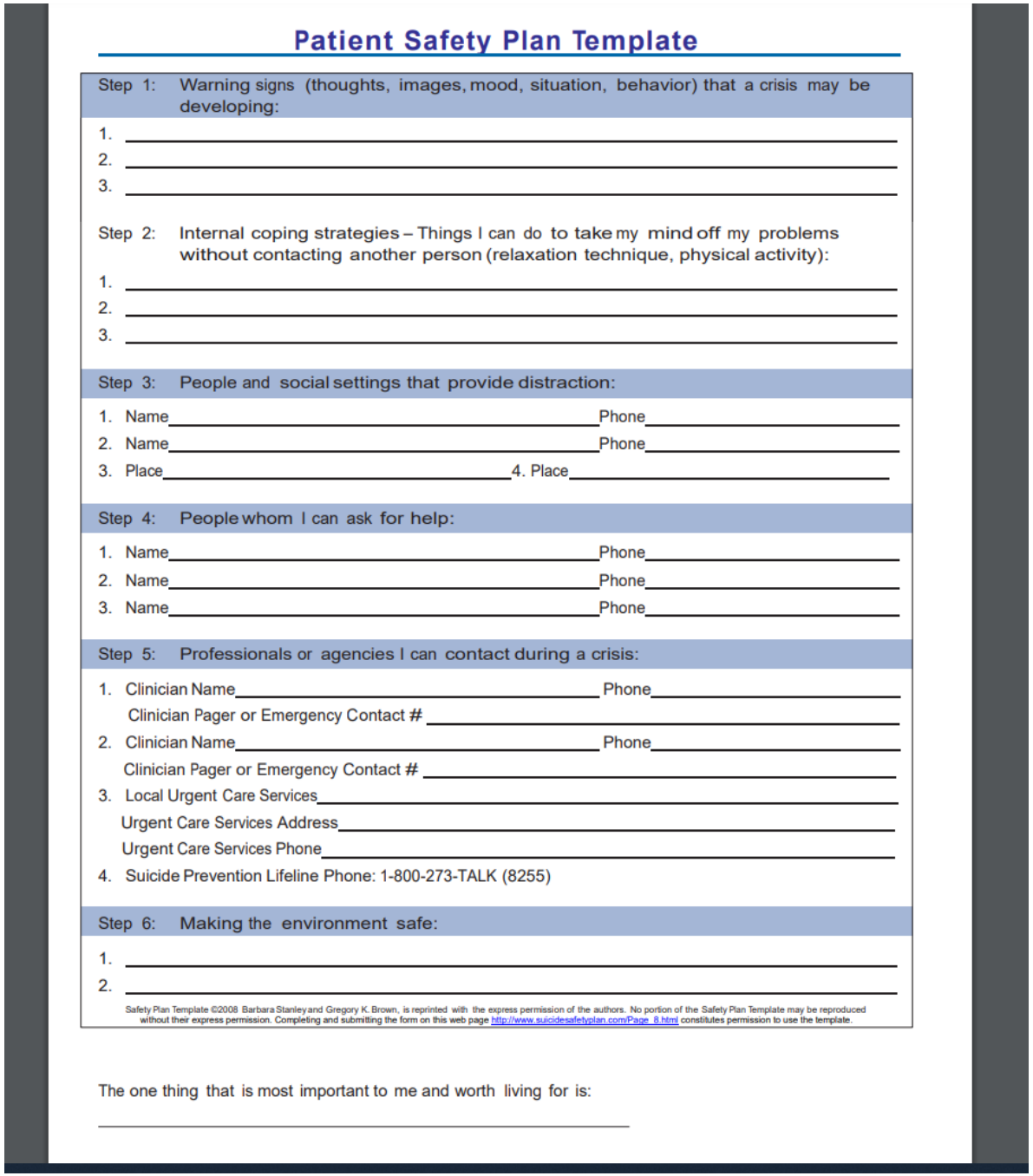
The Safety Plan



Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

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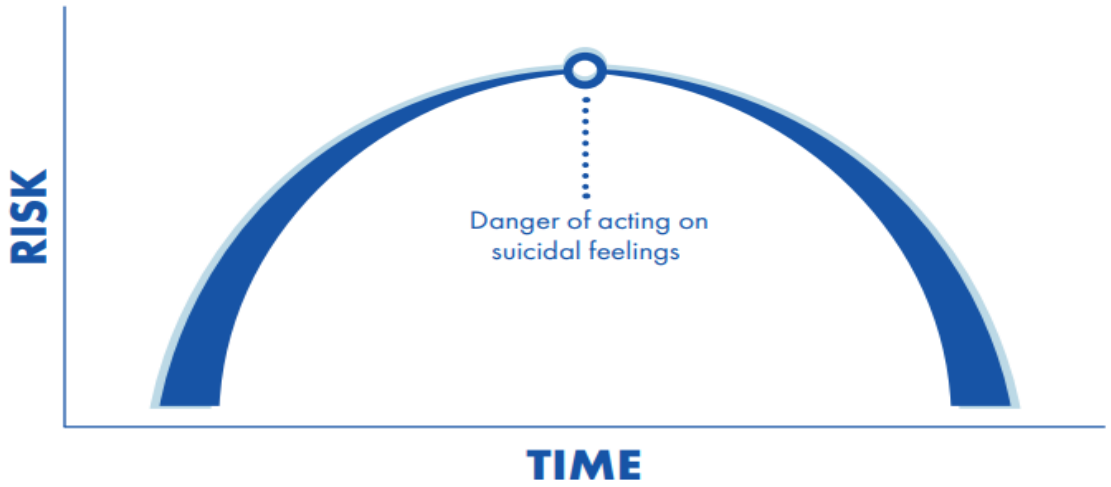
SUICIDE RISK CURVE



Why is it important to understand the suicide risk curve ?

- People at risk for suicide are likely to experience changes in their level of risk over time; acute suicide risk usually increases and then decreases over a short period of time.
- The goal of safety planning is for people to become more aware of their personal warning signs that a suicidal crisis is beginning or escalating so that they can take action before they are in danger of acting on their suicidal feelings.

Stanley-Brown
Safety Planning Intervention

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Highlight Reel

9.16.26

Tara Whitaker, MD

ECHO panelist

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Highlight #1: Medical causes of psych illness

- Autoimmune psychosis
  - Psychosis that is accompanied by progressive neuro deficits
- Vitamin deficiencies
- Hormonal contributors
  - Menopause and perimenopause
    - Can produce significant psychiatric and sleep disturbances
      - Hormonal intervention can help and should not be withheld
      - However, don't overvalue the hormonal component if severe mental illness is present and needs more urgent or direct psychiatric intervention
      - Psych and hormone care can be synergistic
  - Thyroid issues
  - Insulin and blood sugar regulation
    - Stay tuned for the evolution of GLP-1 use in addiction and the mental illness connection!

Highlight #2: Polypharmacy

- Always question medication contribution in mental illness
  - Many medications used for other purposes can cause psychiatric illness
    - Antihistamines, birth control, blood pressure and cardiac medications, etc.
  - Contribution can be significant, especially in older patients
  - Watch out for anticholinergic side effects
    - You can calculate the burden, these drugs can be particularly harmful in geriatrics
      - https://www.acbcalc.com
  - Talk to your pharmacists early and often!
  - Many psych meds have physical side effects that can be burdensome and dangerous, coordinate with primary care to ensure safety and keep patients compliant!

Highlight #3: Nature therapy

- Nature based therapies and exposure is a simple and affordable way to improve mental health across multiple areas
  - Improvement in cognitive function
  - Improved brain activity
  - Blood pressure support and stress reduction
  - Improved sleep
  - Mood improvement
  - Decreased anxiety
  - ADHD symptom improvement

- Int J Environ Res Public Health. 2021 Apr 30;18(9):4790. doi: 10.3390/ijerph18094790

Highlight #4: Gender Dysphoria

- This is an important condition for all practitioners to be familiar with.
- Though knowledge does continue to evolve, creating safe, supportive environments for gender diverse patients and those with gender dysphoria has been clearly demonstrated to improve outcomes mentally and physically for all ages
- There are international guidelines and specialty guidelines to follow in the care of gender diverse patients and in the treatment of gender dysphoria. These are standard of care and should be followed.
- Please reach out to your local experts and refer to national resources to learn more if this topic is unfamiliar or was not covered in your educational program

Highlight # 4 cont.: Resources for gender dysphoria treatment and care of gender diverse patients

- Guidelines and care guides
  - World Professional Association for Transgender Health
    - Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (SOC 8)
      - https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644
  - Endocrine Society Guideline
    - Gender Dysphoria/Gender Incongruence Guideline Resources
    - https://www.endocrine.org/clinical-practice-guidelines/gender-dysphoria-gender-incongruence
  - UCSF Care guideline:
    - Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People (planning update in 2026)
    - https://transcare.ucsf.edu/guidelines

Key Points

- ECHO Behavioral Health taught me so much. I hope it was helpful to our audience that tuned in. I will miss it!!

- Very special thank you to Shannon and our team of wranglers. This has been an excellent team to work with from beginning to end

- Final take-home from the series — interdisciplinary care for patients is essential, especially for patients with mental health challenges. Involving and communicating across disciplines enriches care and significantly improves care plans! Thank you all!

References

- Additional references available upon request!

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Cannabis and Mental Health: Key Risks

- ~30% of past-year cannabis users meet criteria for CUD; ~half have moderate-to-severe disease
- Psychosis risk: 2- to 11-fold increased risk with regular use, especially adolescents/young adults using high-THC products
- Bipolar disorder: worsened mania, decreased likelihood of recovery
- Depression: CUD associated with increased suicidal ideation and attempts
- Anxiety: high-potency cannabis associated with ~2-fold increased risk
- Cognition: impaired verbal learning, working memory, executive function
- Key message: No scientific evidence supports cannabis as treatment for any psychiatric illness

Cannabis Withdrawal Syndrome

- Occurs in ~50% of daily users upon cessation
- Onset: 1–2 days; peak: 2–6 days; duration: up to 3 weeks
- Symptoms: irritability, anxiety, depressed mood, insomnia, decreased appetite, restlessness, chills, headache, sweating
- Overlaps significantly with nicotine withdrawal
- Management: psychoeducation, CBT, symptom-targeted meds, slow tapering

Cannabis-Induced Psychosis

What Is Cannabis-Induced Psychosis (CIP)?

- THC can induce a transient psychotic state — typically lasting hours, but sometimes persisting well beyond acute intoxication
- Transient psychotic symptoms during cannabis intoxication reported by 5–50% of adults
- Rates of CIP are increasing — partly attributable to rising THC potency and increasing CUD prevalence

The Potency Problem

- THC concentration in seized cannabis resin increased nearly 4-fold (8.3% → 31.2%) from 2000–2022 in Denmark
- Population-level data: rising THC potency is positively associated with cannabis treatment admissions, CIP incidence, and dual diagnosis (schizophrenia + CUD)
- High-potency cannabis use associated with 2× the odds of incident psychotic experiences (OR 2.15, 95% CI 1.13–4.06)
- Systematic review (20 studies): higher potency cannabis consistently associated with increased risk of psychosis and CUD

Acute Management

- No FDA-approved antidote or specific treatment for CIP
- Supportive care: quiet environment, reassurance
- Severe agitation/anxiety → benzodiazepines
- Psychotic symptoms → second-generation antipsychotics (risperidone most commonly used; mean dose ~8 mg/day in one study)
- Inpatient admission if severe mood or psychotic symptoms (e.g., suicidality)
- Average hospital length of stay for CIP: ~28 days
- Symptoms typically improve significantly by day 22 of treatment

Investigational pharmacotherapy

No FDA-approved medications exist for CUD; psychosocial interventions remain first-line

Export

Agent	Mechanism	Dose	Key Finding	Limitation
NAC	Glutamate modulation	1200 mg BID	Doubled abstinence odds — only when paired with contingency management	No benefit without behavioral co-intervention
Gabapentin	Ca^{2+} channel / GABA modulation	1200 mg/day	Reduced use, withdrawal, and cravings (single trial, n=50)	Unreplicated; single small proof-of-concept
Topiramate	GABA agonist / glutamate antagonist	Up to 200 mg/day	Reduced cannabis use frequency/amount	Poor tolerability; cognitive side effects; high dropout
Varenicline	Partial nAChR agonist	1 mg BID	Possible benefit in men; lower urine THC levels	No overall main effect; sex-specific finding needs replication
Nabiximols	THC + CBD oromucosal spray	Self-titrated	Fewer use days (35 vs 53); more achieved ≥50% reduction (NNT=4)	Not available in US; no significant abstinence benefit
CBD	Endocannabinoid modulation	400–800 mg/day	Reduced use and withdrawal in phase 2a dose-finding trial	Early-phase only; requires high doses unavailable OTC

Bottom Line: Nabiximols and CBD show the most consistent signals for reducing use; gabapentin has the strongest single-trial data for withdrawal/cravings. All agents require larger confirmatory

Collaborative Care as a Psychiatric NP

- Psychologist: diagnostic clarification, psychological testing, clinical formulation, and treatment recommendations.
- Therapist: symptom updates, coping skills, trauma work, safety planning, and progress in therapy goals.
- Psychiatrist: consultation on complex cases, diagnostic uncertainty, medication strategy, and higher-risk clinical decisions.
- Primary Care: medical contributors to psychiatric symptoms, labs, chronic conditions, medication interactions, and overall physical health.
- Pharmacist: medication safety, interactions, side effects, dosing, adherence barriers, and patient education.

Collaboration improves safety, reduces fragmented care, and supports whole-person treatment

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Endgame

And Thank You

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“The idea was to bring together a group of remarkable people to see if they could become something more. To see, if they could work together when we needed them to, to fight the battles we never could.”

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