Safety Action Series

Collaborative Care Models for Perinatal Mental Health:
A Systems Approach to Adopting Best Practices
Speakers

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Disclosures

➢ Nancy Grote, PhD, MSW has no real or perceived conflicts of interest.

➢ Emily Miller, MD, MPH has no real or perceived conflicts of interest.
Objectives

- Discuss common barriers to mental health care and provide an overview of frequent issues in the current care models for maternal and perinatal mental health.
- Define the collaborative care model and explain characteristics and methodologies of successful approaches to improving perinatal and maternal mental health care on an institutional level.
- Provide insight on the significance of cultivating a culture of teamwork and promoting collaboration between disciplines throughout maternal and perinatal care.
- Share real world examples of versatile institutional systems that have implemented a collaborative care framework in their maternal and perinatal mental health programs and discuss the successes and challenges faced.
Perinatal Depression

1. Diminished interest/pleasure
2. Depressed mood
3. Change in sleep
4. Low energy
5. Change in appetite
6. Worthlessness/guilt
7. Poor concentration
8. Psychomotor changes
9. Thoughts of death/suicide
Why Should I Screen?

- Cardiac disease
- Other indirect causes
- Indirect neurological conditions
- Sepsis
- Pre-eclampsia and eclampsia
- Thrombosis and thromboembolism
- Amniotic fluid embolism
- Psychiatric causes
- Early pregnancy deaths
- Haemorrhage
- Anaesthesia
- Other direct
- Indirect malignancies
Why Should I Screen?

Wisner K et al. JAMA Psych 2013
Why Should I Screen?

- Suicide or accidental overdose: n=63
- Motor vehicle crash: n=36
- Non-cardiovascular conditions: n=35
- Cardiovascular conditions: n=22
- Embolism: n=19
- Homicide: n=15
- Infection: n=10
- Hemorrhage: n=7
- Undetermined: n=2
- Other trauma: n=2

Percentage of all maternal deaths
Risks of Untreated Depression

Symptoms MDD = *physiologic* dysregulation

- Appetite and nutrition effects
  - Micronutrient deficiencies
  - Inadequate weight gain
  - Overweight/obesity
- Increased inflammation
- Dysregulation of HPA axis

*Preterm birth*
*Low birth weight*
*Gestational diabetes*
*Preeclampsia*

Sit D et al Bipolar Disord 2014
Davis EM et al Matern Child Health J 2012
Coussons-Read ME et al Brain Behav Immun 2012
Hoffman MC et al Obstet Gynecol 2016
Risks of Untreated Depression

Symptoms MDD = *psychosocial* sequelae

- Underutilization of health care
- Alcohol, drug use, smoking
- Loss of interpersonal and financial resources
- Capacity for maternal attachment behaviors

Stein A et al Lancet 2014
Howard LM et al Lancet 2014
Metz TD et al Obstet Gynecol 2016
## DSM-IV Disorders

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unipolar depression</td>
<td>68.5%</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>22.6%</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>5.6%</td>
</tr>
<tr>
<td>Substance use disorder</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Wisner K et al. JAMA Psych 2013
Current Model of Care

- Patient screens positive
- Clinical assessment
  - Initiate pharmacotherapy
  - Refer for mental health care
- Patient attends visit

1/10 women with perinatal depression will receive adequate mental health treatment.
Consensus Bundle on Maternal Mental Health

Perinatal Depression and Anxiety

Susan Kendig, JD, MSN, John P. Keats, MD, CPE, M. Camille Hoffman, MD, MScS, Lisa B. Kay, MSW, MBA, Emily S. Miller, MD, MPH, Tiffany A. Moore Simas, MD, MPH, Ariela Frieder, MD, Barbara Hackley, PhD, CNM, Pve Indman, EAD, MFT, Christena Raines, MSN, RN, Kisha Semenuk, MSN, RN, Katherine L. Wisner, MD, MS, and Lauren A. Lemieux, BS

Box 1. Maternal Mental Health: Perinatal Depression and Anxiety Patient Safety Bundle: Council on Patient Safety in Women’s Health Care

Readiness (Every Clinical Care Setting)

1. Identify mental health screening tools to be made available in every clinical setting (outpatient obstetric clinics and inpatient facilities)
2. Establish a response protocol and identify screening tools for use based on local resources
3. Educate clinicians and office staff on use of the identified screening tools and response protocol
4. Identify an individual who is responsible for driving adoption of the identified screening tools and response protocol

Recognition and Prevention (Every Woman)

5. Obtain individual and family mental health history (including past and current medications) at intake, with review and updates as needed
6. Conduct validated mental health screening during appropriately timed patient encounters, to include both during pregnancy and in the postpartum period
7. Provide appropriately timed perinatal depression and anxiety awareness education to women and family members or other support persons

Response (Every Case)

8. Initiate a stage-based response protocol for a positive mental health screening result
9. Activate an emergency referral protocol for women with suicidal or homicidal ideation or psychosis
10. Provide appropriate and timely support for women, as well as family members and staff, as needed
11. Obtain follow-up from mental health care providers on women referred for treatment (this should include release of information forms)

Reporting and Systems Learning (Every Clinical Care Setting)

12. Establish a nonjudgmental culture of safety through multidisciplinary mental health rounds
13. Perform a multidisciplinary review of adverse mental health outcomes
14. Establish local standards for recognition and response to measure compliance, understand individual performance, and track outcomes
MOMCare: Collaborative Care for Depression in Women during Pregnancy

Nancy K. Grote, Ph.D., MSW

School of Social Work, University of Washington

ngrote@uw.edu
MOMCare: A 5-year Randomized Effectiveness Trial of Collaborative care for Perinatal Depression

- 10-site effectiveness study in Seattle-King County public health system – funded by NIMH (R01-MH084897)
- 168 pregnant women on Medicaid
- 3 depression care specialists (DCSs) cover 10 public health centers trained in 3 main components of MOMCare
  *1) pre-treatment engagement session
  *2) culturally relevant Brief Interpersonal Psychotherapy
  3) pharmacotherapy (in collaboration with OB provider & MOMCare team psychiatrist)
Key Principles of Collaborative Care

1. CC team approach – multidisciplinary
2. Standardized depression measure (PHQ-9)
3. Patient education and activation
4. Population-based tracking forms to monitor evidence-based treatment visits (e.g., psychotherapy/medication doses) – reminders for patient follow-up/contacts
5. Caseload supervision by team leader – M.D.
6. Stepped care adjustments of treatment
7. Relapse Prevention
During your pregnancy, do you feel...

- hassled?
- no energy?
- sad?
- stressed?
- no pleasure?

**MOMcare** offers a **free, brief screening** at this public health center to see if our treatment services are right for you.

If you are eligible and choose to enter the **MOMcare** program, you will receive **$30 for each of 5 interviews (total $150)** to compensate you for your time and effort.

To be eligible for **MOMcare** you must be **18 years or older and 12-32 weeks pregnant**.

If you enroll in **MOMcare**, you will meet with a **depression care specialist** who will give you information about available treatment options and connect you with the treatment you want.

**MOMcare** is a **depression treatment research study** from the University of Washington in partnership with Public Health Seattle-King County.

For HELP call Erin at **mOMcare**

206-239-8490

or talk to your MSS provider

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SCHOOL OF SOCIAL WORK
UNIVERSITY OF WASHINGTON

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COUNCIL ON PATIENT SAFETY
IN WOMEN'S HEALTH CARE

safe health care for every woman
An Ecological Model of Barriers to Treatment Engagement and Retention

**Distal Influences** → **Proximal Influences** → **Rx Adherence** → **Rx Outcome**

**Community Barriers**
- Violence, safety concerns, lack of support services, unemployment; poverty, lack of access to M.H. services, chronic stressors

**Helping System Barriers**
- Bias or cultural insensitivity in environment, procedures, providers lack evidence based treatments
- Lack of diversity in clients & staff provider overload and burnout

**Social Network Barriers**
- Negative attitudes towards rx
- Social network strain
- Chronic stressors

**Client Barriers**
- **Practical** – time, financial, transportation, child care
- **Psychological** – stigma, low energy, negative rx experiences
- **Cultural** – women’s view of depression
- Multiple stressors/coping strategies
- Strong self-reliance
Engagement Session: 5 Components

(unpublished manual, Zuckoff, Swartz, Grote et al.)

Total time: 50-60 minutes – Before treatment agreed upon

1) Getting her story – how she is feeling? How is it interfering with what is important to her?

2) Past efforts at coping and attitudes toward treatment/therapist

3) Feedback and psychoeducation about depression and its treatment

4) Addressing practical, psychological, and cultural barriers to care
   a. Explore potential differences between women and her therapist – race/ethnicity/nationality, SES, gender, etc. - * Tonya

5) Eliciting commitment and planning for treatment engagement
After Pre-treatment Engagement: Choice of treatment for depression during the perinatal risk period

**ACUTE Brief IPT and/or Meds**

Goal
Reduce antenatal depression BEFORE BIRTH

**IPT and/or Meds Maintenance**

Goal
Reduce antenatal depression AFTER BIRTH
What Comes after Engagement? - Interpersonal Psychotherapy (IPT)

- Time-limited (12-16 weeks) individual psychotherapy for depression
- Structured, manualized treatment that has been used in research protocols – see meta-analysis by Cuijpers et al., 2011:
  - IPT efficaciously treats depression, both as an independent treatment and in combination with pharmacotherapy
- Demonstrated efficacy in general and for antenatal depression and postpartum depression (Grote et al., 2009; 2015; O’Hara, Stuart et al., 2000; Spinelli & Endicott, 2003; Spinelli et al., 2016)
- Therapists and patients like it: “it makes sense”
Cultural Enhancements to Brief IPT
(Grote et al., 2009, Psychiatric Services, 60, 313-321)

- **Pragmatic enhancements regarding culture of poverty:**
  - Case management; facilitation of access to social services; offering rx in a non-stigmatizing public health setting, phone therapy

- **Enhancements for race/ethnicity/nationality** (Bernal et al., 1995)
  - Providing psychoeducation and treatment information in line with patient’s cultural preferences and values
    - e.g. therapy = a class; depression could be re-labeled “stress,” “nerves”
  - Treatment setting served others from same racial/ethnic group
  - Incorporating cultural resources and strengths
  - Using stories from patient culture to support treatment goals
Randomized Controlled Trial

Eligible Pregnant Women (n=168)

Age ≥ 18; Major Depression or Dysthymia

Referral to OB provider and/or community mental health

Intensive Maternity Support Services (MSS-Plus)
Before birth to 2-months PP (n=85)

Pre-Rx Engagement Session Choice of brief IPT &/or Meds

MSS-Plus & brief IPT/ Meds
Before birth to 1-year PP (n=83)

3-, 6-, 12- and 18-month post-baseline follow-ups (before birth up to 1 year postpartum)
MOMCare Sample

- Sample – 168 depressed, pregnant women on Medicaid from PHSKC MSS

- Inclusion criteria:
  - > 18 years old
  - 12-32 weeks pregnant
  - MDD or Dysthymia
  - Access to household phone
  - Fluent in English

- Exclusion criteria:
  - Suicidal/homicidal
  - Psychotic/organic problem
  - History of mania
  - Recent drug/alcohol abuse
  - Receiving psychotherapy
  - Severe intimate partner violence
**Demographic and Clinical Variables for Study Participants (N=168)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years</td>
<td>27.4 (18-44)</td>
</tr>
<tr>
<td>Weeks pregnant</td>
<td>22.4 (12-32)</td>
</tr>
<tr>
<td>Married</td>
<td>29%</td>
</tr>
<tr>
<td>Non-White</td>
<td>58%</td>
</tr>
<tr>
<td>Homeless</td>
<td>13%</td>
</tr>
<tr>
<td>Some college or higher</td>
<td>59%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>65%</td>
</tr>
<tr>
<td>Income: less than or = to $10K</td>
<td>42%</td>
</tr>
<tr>
<td>Unplanned Pregnancy</td>
<td>72%</td>
</tr>
<tr>
<td>Major Depression/Dysthymia</td>
<td>100%</td>
</tr>
<tr>
<td>PTSD</td>
<td>65%</td>
</tr>
<tr>
<td>At least one childhood trauma</td>
<td>53%</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>32%</td>
</tr>
<tr>
<td>Emotional neglect</td>
<td>39%</td>
</tr>
<tr>
<td>Fearful attachment orientation</td>
<td>47%</td>
</tr>
</tbody>
</table>
Treatment Choices of Intervention Group (n=79)

- 80% started with Brief IPT (n=63)
  - of those who started with brief IPT, 36% (n=23) augmented with medication across the study period

- 15% started with Brief IPT and medication (n=12)

- 5% have selected anti-depressant medication alone (n=4)
Will the MOMCare intervention lead to more treatment engagement and retention than public health MSS-Plus?
MOMCare Engagement Results:
% Attendance at an Initial Treatment Session

* Less than 1/3 of phone intakes attend 1 Rx session in community mental settings
Retention in Treatment: Average Number of Acute Sessions Attended and Attrition

MSS n = 81
MOMCare n = 81

Typical number of Rx sessions attended in community mental health = 1
Study attrition rate = 5% in both treatment groups
Will the MOMCare intervention be more effective than public health MSS in reducing depressive symptoms and improving social functioning before and after the birth?

- **Main effects for treatment group:**
  - SCL-20, $p = .01$
  - Remission on the SCL-20 ($<.5$), $p = .05$
  - Work and social functioning, $p = .09$
  - PTSD severity, $p = .04$

Grote et al., Depression and Anxiety, 2015
SCL 20 For Intervention Groups in MOMCare and MSS

Group x time interaction = NS  Main effect for time significant.
Main effect for group significant (effect size .35)
Overall SCL-20 Remission Rates across Study Period

Baseline 3 mo 6 mo 12 mo 18 mo

Brief IPT/ Meds Maintenance

p = .05
➢ To what extent will co-morbid PTSD moderate the effects of MOMCare compared to public health MSS-Plus on depression severity?

• 65% of the sample met criteria for probable PTSD at baseline on the PCL-C

Grote et al., 2016, *Journal of Clinical Psychiatry*
**SCL 20 For Intervention Groups with MDD & PTSD**

Significant main effect for treatment group

**Effect size = .44**
Remission of Depression Symptoms (SCL-20<.5) for Women with Comorbid PTSD Receiving MOMCare Intervention and MSS-Plus.

Main effect for group: p=.02
To what extent does MOMCare versus MSS-Plus protect women with one or more unplanned, adverse birth events from PPD and impaired functioning?
MSS-Plus Comparison Group: SCL-20 Depression by Birth Event Group

Graph showing the comparison between MSS-Plus and SCL-20 Depression scores over time (Baseline, 6 Month, 12 Month, 18 Month) for individuals with and without adverse events.
Challenges

1. When patient does not come in as scheduled – patients who have disengaging attachment styles – not taking it personally

2. Making sure everyone on the CC team is fully informed

3. Working on relapse prevention and using relapses as an opportunity for learning

4. Patients who have cell phones that are periodically turned off
Comments from our Intervention Participants about What is Helpful

- “You help me plan what I’m going to do”
- “I don’t feel so alone”
- “You help me see I am making progress”
- “It helps just to talk and get my feelings out”
- “You have confidence in me”
Final Observations:

1) The timing of depression amelioration after childbirth is critical, given the well-established adverse effects of postpartum depression on maternal and infant health and mental health.

2) Most women did not want anti-depressant medication, but did want psychotherapy and case management.

3) Most women appreciated the flexible scheduling of rx appointments in the clinic or by phone.

4) Public health centers are great places to connect with this population--convenient, non-stigmatizing settings serving a diverse pregnant population on low incomes.

5) Take Home Message: Screen for PTSD during pregnancy, track adverse birth outcomes and add more intensive MSS depression care services from pregnancy up to one-year postpartum.
A Collaborative Care Model for Perinatal Depression Support Services (COMPASS)
Team

**COMPASS Program Director**
Emily Miller

**COMPASS Care Coordinator (CCC)**
Rebekah Jensen

**Psychiatrists**
Dana Mahmoud
Lisette Rodriguez-Cabezas

**Therapist**
TBD

**Clinical Liaison**
Jackie Gollan
- Obstetrician education
- Collaborative care model
  - On-site mental health services
- Assessment of patient-centered and health services utilization outcomes
Obstetrician Education

Training program:
• Screening protocols
• Clinical evaluations
• Treatment algorithms
• Medications in pregnancy resource guide

Training venues:
• Grand rounds
• Resident didactics
• Fellow didactics
• Division/clinical practice meetings
Depression Screening Algorithm for Obstetric Providers

The PHQ-9 should be administered during:

- Initial intake or first obstetric visit
- Visit in 3rd trimester
- If high-risk* patient, 2 weeks post-partum
- 6 weeks post-partum visit

**PHQ-9 Score < 10**

Does not suggest depression

- Educate patient about the importance of emotional wellness.
- Provide COMPASS brochure for future reference.

**PHQ-9 Score ≥ 10**

May suggest depression

- (1) Assess patient clinically
  Consider comorbid illnesses, such as substance use or medical causes of depression (e.g. anemia, thyroid disorders)
  (2) Score of 2+ (more than half of the time) on questions #1 (anhedonia) or #2 (depressed mood) likely indicate depression.
  (3) Screen for Bipolar Disorder using MDQ (Mood Disorder Questionnaire)

**Positive score on question #9**

Suggests risk of self-harm or suicide

- Assess for risk of suicide or harm
  Do NOT let the patient leave without developing a safety plan. Further assessment or treatment plan must be established and documented in medical record.
  Call COMPASS Care Coordinator

For clinical concerns of mental illness, contact COMPASS Care Coordinator Rebekah Jensen at 312.926.8347 (Room 14-239, Pager 5-7859)

COMPASS collaborates with you and the patient to determine a treatment plan that can include on-site psychotherapy and/or psychiatry consultation, then follows-up with you and the patient frequently until remission.

(*) High-risk = history of depression or PHQ-9 score ≥ 10, those taking or who have taken psychiatric medications, or other risk factors for depression
# Antidepressant Treatment Algorithm

**Reevaluate** depression treatment every 2 weeks via PHQ-9 and clinical assessment

<table>
<thead>
<tr>
<th>Antidepressant</th>
<th>Recommended Dose</th>
<th>Increase Increments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sertraline (Zoloft)</td>
<td>50-200 mg</td>
<td>Increase in 50 mg increments</td>
</tr>
<tr>
<td>Fluoxetine (Prozac)</td>
<td>20-60 mg</td>
<td>Increase in 10 mg increments</td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
<td>10-40 mg</td>
<td>Increase in 10 mg increments</td>
</tr>
<tr>
<td>Escitalopram (Lexapro)</td>
<td>5-20 mg</td>
<td>Increase in 5 mg increments</td>
</tr>
</tbody>
</table>

If PHQ-9 remains ≥ 5...
- If no/minimal side effects → increase dose and/or add psychotherapy
- If side effects* → consider switching to different medication
- Consider contacting COMPASS Care Coordinator to facilitate psychiatry consultation

If PHQ-9 is < 5 and no/minimal side effects...
- Reevaluate every month and at postpartum visit

**Educate Patient:** Within first few doses, if she has marked increase in anxiety, becomes agitated, or feels energized, stop the medication and contact COMPASS.

*Common side effects of SSRI include: nausea, dry mouth, insomnia, diarrhea, headache, dizziness, agitation, sexual problems, and drowsiness
General Overview:

- No decision during pregnancy is risk free
- SSRI (Selective Serotonin Reuptake Inhibitors) are among the best studied class of medications during pregnancy
- Both medication and non-medication options should be considered
- Encourage non-medication treatments (e.g., psychotherapy) in addition to medication treatment and/or as an alternative when clinically appropriate

<table>
<thead>
<tr>
<th>Antidepressant use during pregnancy may increase risk of...</th>
<th>Risks of under-treatment or no treatment of depression during pregnancy...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transient neonatal signs</td>
<td>Postpartum depression</td>
</tr>
<tr>
<td>Long-term developmental effects, but data are consistent that cognitive development is within normal limits</td>
<td>Pre-eclampsia</td>
</tr>
<tr>
<td>Recent well-controlled, large studies show that antidepressants do not increase the risk of birth defects</td>
<td>Pre-term labor</td>
</tr>
<tr>
<td></td>
<td>Substance abuse</td>
</tr>
<tr>
<td></td>
<td>Suicide</td>
</tr>
<tr>
<td></td>
<td>Poor self-care</td>
</tr>
<tr>
<td></td>
<td>Impaired bonding with baby</td>
</tr>
<tr>
<td></td>
<td>Risk of mental health disorders in offspring</td>
</tr>
<tr>
<td></td>
<td><strong>Perinatal depression is associated with negative outcomes for mother, baby, and family</strong></td>
</tr>
</tbody>
</table>
# Antidepressant Medications

<table>
<thead>
<tr>
<th>Drug</th>
<th>Starting Dose</th>
<th>Side Effects</th>
<th>Specific Drug Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sertraline</td>
<td>Prescribe 50 mg base, 1 tablet daily, increasing by 25 mg daily if tolerated to a maximum of 200 mg/day</td>
<td>Drowsiness, nausea, insomnia, sexual dysfunction, tremors, weight loss, agitation</td>
<td>First line in pregnancy and lactation due to minimal risk for interaction with other drugs, tolerability, and low rate of neural discontinuation signs in infants born to treated pregnant women</td>
</tr>
<tr>
<td>Citalopram</td>
<td>Prescribe 20 mg base, 1 tablet daily, increasing by 10 mg daily if tolerated to a maximum of 40 mg/day</td>
<td>Drowsiness, nausea, insomnia, sexual dysfunction, tremors, weight loss, agitation</td>
<td>Citalopram and Escitalopram are not recommended for patients with congenital long QT syndrome, bradycardia, hypokalemia, or hypomagnesemia, recent acute myocardial infection, or uncorrected heart failure. Citalopram should be used with monitoring of the EKG in patients who are taking other drugs that prolong the QT interval (amiodarone, hydroxychloroquine, quinidine, sotalol, methadone)</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>Prescribe 10 mg base, 1 tablet daily, increasing by 10 mg daily if tolerated to a maximum of 20 mg/day</td>
<td>Drowsiness, nausea, insomnia, sexual dysfunction, tremors, weight loss, agitation</td>
<td>Second line drug. Anticholinergic weight gain, significant withdrawal syndrome, and minimal discontinuation signs for infants of treated pregnant women</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>Prescribe 20 mg base, 1 tablet daily, increasing by 10 mg daily if tolerated to a maximum of 60 mg/day</td>
<td>Drowsiness, nausea, insomnia, sexual dysfunction, tremors, weight loss, agitation</td>
<td>Second line drug. More anticholinergic side effects than SSRIs; significant withdrawal syndrome even with missed doses and minimal discontinuation signs for infants of treated pregnant women</td>
</tr>
</tbody>
</table>

**SSRIs**

<table>
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<tr>
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<td>Escitalopram</td>
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<td>Drowsiness, nausea, insomnia, sexual dysfunction, tremors, weight loss, agitation</td>
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**SNRIs**

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<td>Drowsiness, nausea, insomnia, sexual dysfunction, tremors, weight loss, agitation</td>
<td>Citalopram and Escitalopram are not recommended for patients with congenital long QT syndrome, bradycardia, hypokalemia, or hypomagnesemia, recent acute myocardial infection, or uncorrected heart failure. Citalopram should be used with monitoring of the EKG in patients who are taking other drugs that prolong the QT interval (amiodarone, hydroxychloroquine, quinidine, sotalol, methadone)</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>Prescribe 10 mg base, 1 tablet daily, increasing by 10 mg daily if tolerated to a maximum of 20 mg/day</td>
<td>Drowsiness, nausea, insomnia, sexual dysfunction, tremors, weight loss, agitation</td>
<td>Second line drug. Anticholinergic weight gain, significant withdrawal syndrome, and minimal discontinuation signs for infants of treated pregnant women</td>
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</tr>
</tbody>
</table>

**Other**

<table>
<thead>
<tr>
<th>Drug</th>
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<th>Side Effects</th>
<th>Specific Drug Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram</td>
<td>Prescribe 20 mg base, 1 tablet daily, increasing by 10 mg daily if tolerated to a maximum of 40 mg/day</td>
<td>Drowsiness, nausea, insomnia, sexual dysfunction, tremors, weight loss, agitation</td>
<td>Citalopram and Escitalopram are not recommended for patients with congenital long QT syndrome, bradycardia, hypokalemia, or hypomagnesemia, recent acute myocardial infection, or uncorrected heart failure. Citalopram should be used with monitoring of the EKG in patients who are taking other drugs that prolong the QT interval (amiodarone, hydroxychloroquine, quinidine, sotalol, methadone)</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>Prescribe 10 mg base, 1 tablet daily, increasing by 10 mg daily if tolerated to a maximum of 20 mg/day</td>
<td>Drowsiness, nausea, insomnia, sexual dysfunction, tremors, weight loss, agitation</td>
<td>Second line drug. Anticholinergic weight gain, significant withdrawal syndrome, and minimal discontinuation signs for infants of treated pregnant women</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>Prescribe 20 mg base, 1 tablet daily, increasing by 10 mg daily if tolerated to a maximum of 60 mg/day</td>
<td>Drowsiness, nausea, insomnia, sexual dysfunction, tremors, weight loss, agitation</td>
<td>Second line drug. More anticholinergic side effects than SSRIs; significant withdrawal syndrome even with missed doses and minimal discontinuation signs for infants of treated pregnant women</td>
</tr>
</tbody>
</table>

**Antidepressant Medication Warnings/Precautions:** 1) Potential increased suicidality at the start of treatment; if anxiety increases or patient becomes agitated or agitated, discontinue the antidepressant and have patient contact prescriber; 2) Discontinuation symptoms (similar to flu) may occur with abrupt discontinuation.

**About Serotonin Syndrome—overstimulation of serotonin receptors:** Serotonin syndrome symptoms usually occur within several hours of taking a new drug or increasing the dose. Signs and symptoms include: agitation or restlessness, confusion, rapid heart rate and high blood pressure, dilated pupils, muscle incoordination, sweating or rigidity, high fever, sedation, headache, liver failure, delirium, hallucinations, cardiac arrest, hyperthermia, increased blood pressure, kidney failure, hypertension, and coma. Physical symptoms may include tremors, diaphoresis, myoclonus, shivering, confusion, agitation, hallucinations, hyperreflexia, seizures, hyperpyrexia, tachycardia, and ictal activity.
Core Principles of Collaborative Care

- Patient centered team care
- Population-based care
- Measurement-based treatment to target
- Evidence-based care
- OB prescribes pharmacotherapy
- CCC follows patient with serial PHQ9s
- COMPASS care team review weekly
Implementation of Collaborative Care: Preparation

- Design YOUR CC model
- Involve administration early
- Develop clinical algorithms
- Engage stakeholders
- Collect data
- Bring in an expert
Q&A Session
Press *1 to ask a question

You will enter the question queue
Your line will be unmuted by the operator for your turn

A recording of this presentation will be made available on our website:
www.safehealthcareforeverywoman.org
Next Safety Action Series

Effectively Communicating with Moms About Screening & Treatment for Perinatal Depression & Anxiety

May 19th 2017
1:30 pm Eastern

Lenore Jarvis MD, MEd, FAAP
Assistant Professor of Pediatrics
The George Washington University School of Medicine and Health Sciences
Children's National Health System

Pooja Lakshmin, MD
Assistant Professor of Psychiatry & Behavioral Sciences
The George Washington University School of Medicine and Health Sciences

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