KU SCHOOL OF MEDICINE WICHITA
The University of Kansas
Department of Psychiatry & Behavioral Sciences
1010 N. Kansas
Wichita, KS 67214-3199

Return Service Requested

Non-Profit
Organization
U.S. Postage
PAID
Wichita, KS
Permit #864

FACULTY, STAFF, RESIDENT AND STUDENT NOTES . . .

CONGRATULATIONS

Robin Matson on being selected as our psychology intern for 2006-2007.

PRESENTATIONS

Grand Rounds presentation at the University of Pennsylvania, Department of Psychiatry, Preskorn, SH, Philadelphia, PA, January 26.

Grand Rounds presentation at the University of Kansas Medical Center, Department of Psychiatry, Preskorn, SH, Kansas City, KS, February 3.

Grand Rounds presentation at the State University of New York - Downstate, Department of Psychiatry, Preskorn, SH, Brooklyn, NY, March 22.

PUBLICATIONS

M. I. Ramadan, A. Y. Khan, and W. E. Weston. Response to SSRI-induced .enuresis: a case report. *J.Clin.Psychopharmacol.* 26 (1):98-99, 2006.

Preskorn, SH Drug-drug interactions: Proof of relevance (Part II): cause of tolerability problems or noncompliance. *J.Psychiatr.Pract.* 11 (6):397-401, 2005.

Preskorn, SH. Psychopharmacology and psychotherapy: what's the connection? *J.Psychiatr.Pract.* 12 (1):41-45, 2006.

POSTER PRESENTATIONS

Presented at the ASCPT, "The effect of duloxetine, escitalopram & sertraline on CYP2D6 function", Preskorn, SH, Baltimore MD, March 7-11.

Presented at AAGP: "Mental Illness Stigma Comparison in Geriatric versus Adult Population", Lincoln J, Nabieva G, Marsh C, Zackula R, American Association of Geriatric Psychiatry, San Juan, Puerto Rico, March 12 and at the Fourteenth Annual Research Forum at the University of Kansas School of Medicine-Wichita, April 1.

Matson, R.J., Baade, L.E. and Soetaert, D.K. (2005). An examination of the MMSE and RBANS in detecting dementia in a geriatric inpatient population. Poster presented at the 25th annual meeting of the National Academy of Neuropsychology, Tampa, FL and at the Fourteenth Annual Research Forum at the University of Kansas School of Medicine-Wichita, April 1.

Soetaert D, Dorr DA, Morgan CD, Jones TL. Antisocial Tendencies and Depression on the MACI and MMPI-A. Poster presented at the 113th Annual Convention of the American Psychological Association, Washington, DC in 2005 and at the Fourteenth Annual Research Forum at the University of Kansas School of Medicine-Wichita, April 1.

Matson RJ, Dorr DA, Morgan CD. Relationship of the MMPI-2 PSY-5 Scales to MCMI-III Factor Scales. Poster presented at the 113th Annual Convention of the American Psychological Association, Washington, DC in 2005 and at the Fourteenth Annual Research Forum at the University of Kansas School of Medicine-Wichita, April 1.

Psychiatry and Behavioral Sciences
Communicator
The University of Kansas School of Medicine-Wichita • Department of Psychiatry and Behavioral Sciences

Volume 4 Number 1 May 2006

Adolescent suicide and antidepressants

I run the Inpatient Adolescent Psychiatry Service in Wichita for KUSM-W Department of Psychiatry and Behavioral Sciences and teach medical students and residents rotating through this service.

The goal is to provide a quality experience in the care of adolescents with behavioral disturbances and their families to the medical students and residents by teaching them how to diagnose psychopathology in adolescents and how to work with them and their families. A critical facet of this work is the establishment of a biopsychosocial treatment plan which includes the family and addresses the biopsychosocial issues for each specific patient.

Much has been written about adolescent suicide. There has recently been the addition of black box warnings to the package insert for most of the newer antidepressants about the risk of suicide during treatments with these agents, particularly early in the treatment (i.e., the first several weeks). The addition of this black box warning has caused considerable anxiety about such treatments among families and treatment providers, particularly primary care physicians who may be uncomfortable treating adolescents with psychiatric illnesses and their families. So what are health care providers to do?

First, be aware that there has been a documented decrease in youth suicide rates in the United States since the introduction of SSRI's. Second, a meta-analysis of clinical trials in children and adolescents on nine different antidepressants, including both SSRI and non SSRI antidepressant, found the rate of suicidality (increased suicidal thinking or increased suicide attempts but not completed suicides) was 4% in children and adolescents on an active antidepressant compared to 2% on a placebo, or, in other words, a 2% higher rate. The risk was independent of the underlying diagnosis of the patients, meaning that suicidality was present in patients being treated for depression or anxiety. As mentioned above, the meta-analysis included several antidepressants from different pharmacological classes and each antidepressant did not contribute equally to the signal. Paroxetine and venlafaxine contributed the most, whereas others such as fluoxetine and sertraline contribute little or none. Nevertheless, a black box warning was added to the package insert for all of these medications on the basis of class labeling (i.e., antidepressants as a class).

There are many theories about why antidepressants might increase the risk of suicidal thinking or suicide attempts early in treatment including:

a) worsening of suicide ideation (which was present before)
b) "activation syndrome" with patients becoming agitated, irritable, jitterishness, aggressive, hostile, more impulsive and/or emotionally labile
c) akathisia to hypomania or mania
d) switch to hypomania or mania
e) improving depression - We have known about the phenomenon long before the newer antidepressants (i.e., SSRI's and SNRIs) were marketed. This phenomenon is where the patient's physical symptoms of depression (particularly lack of energy) improve before their emotional and cognitive symptoms improve.
f) lack of response to the antidepressant.

The latter two possible explanations are an admonition to health care providers that starting an antidepressant is alone not sufficient. These medications take time to work. During the vulnerable period between starting the antidepressant and the improvement of depression, the patient remains at risk for suicide. For this reason, the patient needs to be assessed on a frequent basis after starting an antidepressant (weekly) rather than waiting several weeks for the return visit. Unfortunately, insurers have discouraged more frequent visits. The FDA warning was in part in response to this fact.

continued on page 2

INSIDE THIS ISSUE

Is a mental health crisis brewing for Kansas? See the insert page for story by Sheldon H. Preskorn, MD, professor and chair, Department of Psychiatry and Behavioral Sciences.

THIS IS YOUR NEWSLETTER

Let us hear from you!
Contact: Mary Spachek
Call: 316-293-2669
Write: 1010 N. Kansas, Wichita, KS 67214
E-mail: mspachek@kumc.edu

COMMUNICATOR ON LINE

Share the Communicator without giving up your copy. It can viewed at: http://wichita.kumc.edu/psych/ Archived issues can also be viewed.

continued from page 1

So what are health care providers to do when they make the diagnosis of MDD or anxiety disorder and believe that the benefits of medication outweigh the risks?

1. Inform patients and their family about the risks and benefits of treatment versus doing nothing (not treating the depression). In my clinical experience, parents understand numbers - 2% placebo, 4% medication, untreated depression - 15% lifetime risk. Give the patients and their family written information.
2. The best patient is the educated patient (and family). Make sure that you inform them about the symptoms of akathisia, activation syndrome and mania. If the patient and family know what to look for and what to inform you about, then they will inform you.
3) Identify what symptoms you are treating with medication and what are the expectations in terms of time to respond.
4) Carefully document the entire process. What you tell the patient and parents, your clinical judgment about starting medication and the inform consent.
5) Use first line agents - SSRI's - especially agents that are FDA approved to be used in adolescents. Prozac (depression), Zoloft (anxiety). Use Paxil and Effexor as second line agents.
6) Monitor patients closely. The FDA has made the following recommendations for monitoring patients once they are started on an antidepressant.
   - Follow weekly for the first four weeks, then
   - Follow every two weeks for the next two months,
   - Then, monthly
   - And finally at least once every three months with phone contact.

The risk is lower in adolescents treated for more than six months compared to those treated for less than two months, consistent with the fact that the increase early in treatment may be due to incomplete response of the depressive syndrome and thus is a vulnerable time requiring closer follow-up.

So what else are health care providers to do?

1) Do a comprehensive evaluation.
2) Evaluate for suicidality before treatment.
3) Have a comprehensive treatment plan to include medication, education of the patient and family, and psychosocial interventions with the patient and family as needed.
4) Inform patients and parents of the risks and benefits including the black box warnings.
5) Inform of possible triggers for increased suicidality while on medication (as discussed above).

Follow and monitor patients closely, especially the first six months.

Disclosure- this is information based on the review of literature.

National Institute of Health (NIH) Antidepressant and Suicidality Review Panel

By: Sheldon Preskorn, MD

The National Institute of Health/National Institute of Mental Health has established a committee of national and international experts to provide scientific and technical review concerning research into the possible relationship between antidepressant treatment and suicidality.

Dr. Preskorn is one of the 24 experts asked to participate in this process. These experts represent the following institutions: Massachusetts Institute of Technology, Yale University, Columbia University, University of Pennsylvania, Cornell University, Carnegie Mellon University, Baylor University, Rutgers University, University of Rochester, University of Toronto, McGill University, University of California – San Francisco, and State University of New York - Stony Brook.

There has been considerable controversy about the possible relationship between antidepressant treatment and suicide. On one side of the controversy are pharmacoepidemiology studies which indicate that modern antidepressants in general reduce the risk of suicide consistent with their ability to successfully treat major depression, which is the single greatest risk factor for suicide. On the other side is case reports of the emergence of suicidal ideation in individuals suffering from major depression after being started on antidepressants.

Recently, the Food and Drug Administration did a meta-analysis of the clinical trials database from nine different antidepressants tested for efficacy and safety in children and adolescents. While most studies did not support a risk for most antidepressants, the studies with two antidepressants did suggest a possible risk for increase in suicidal ideation but not completed suicide. The meta-analysis also suggested a possible risk of 2% greater likelihood of increased suicidal ideation in children and adolescent early in treatment with an antidepressant versus a placebo control. That led to the addition of a black box warning to the labeling of all antidepressants about the possibility of increased suicidal thinking early in treatment of children and adolescents.

Taken together, antidepressants in general reduce the risk of suicide but may increase the risk in a small percentage of individuals. The NIMH wishes to better understand if that is the case. If so, the next step would be to study whether there are specific risk factors that identify individuals who might have such an increase in suicidal thinking on such medications.

In the event that such individuals are identified, the greatest likelihood is that genetic differences could account for such unusual responses. If so, then tests could be developed which would allow for the early identification of such individuals so that alternative treatments or special monitoring could be done. This line of research would also likely yield a better understanding of the relationship between brain function and risk for depression and response to treatment.

Antidepressant and Suicide Risk in Adults

By: Susan Carr, MD, *Assistant Professor*

Dr. Perales gives a nice discussion of the implications of the black box warnings for possible increased risk of suicide by the newer generation antidepressants when used in adolescents. Concerns about the possibility that antidepressants may increase the risk of suicidal ideation and behavior in adults arose in early 1991, soon after the introduction of fluoxetine into the market. Proving causality in this association has been difficult since patients who are depressed are already at increased risk for suicide. A recently published study (partially funded by the National Institute of Mental Health) of 60,000 enrollees at a nonprofit health care system in Seattle has given good evidence that antidepressants decrease the suicide risk. Results of this study revealed the risk of suicide to be highest in the month before treatment and decrease by 60% in the first month after initiation of the antidepressant.

This study is the first to examine suicide risk before and after patients begin treatment. Other reviews, meta-analysis, and observational studies of suicide risk after initiation of antidepressants do not demonstrate that antidepressants increase the risk of suicidal ideation or completed suicide in adults.

Suicide risk in general is an interest on a local level at the Sedgwick County Suicide Prevention Task Force (SPTF), which has been tracking the suicide rates of varying groups in our community since 2000. The average suicide rate per 100,000 population for Sedgwick County over the past five years was 11.9, compared to a national rate of approximately 10.5 during the same time period. Thirty-two percent of Sedgwick County residents who committed suicide had a diagnosis of depression, but data on antidepressant use is incomplete.

Between 2001 and 2004, the suicide rate per 100,000 of children in Sedgwick County age 0-14 was 0.2, but the rate of 15-24 year olds ran close to 18. The rate of suicides for 45-64 year olds rose to more than 20 in 2003 and 2004. Whether this trend persists is an interest to the SPTF Methodology Committee which will continue to follow this data. Monitoring factors relating to treatment of depression and stressors such as unemployment and divorce may help the task force target prevention efforts.

Dr. Carr is a member of the SPTF Methodology Committee and has been pursuing this research as she works on her Masters in Public Health.

LCME Grants Maximum Accreditation to the School of Medicine

By: Brian Schmidt, *Medical Student Coordinator*

The Liaison Committee on Medical Education (LCME), a national accrediting body for medical schools, recently granted re-accreditation to the Kansas University School of Medicine for the maximum term of eight years, according to Barbara Atkinson, MD, Executive Dean. The LCME cited several areas of strength in the School of Medicine's program, including leadership, library services and information technology resources, engaged students and faculty, and the Office of Medical Education's efforts to monitor and coordinate educational initiatives.

The School of Medicine has been engaged in several projects in preparation for the LCME review, which took place in October, 2005. These projects included a move toward a block-style curriculum for the initial two years of the program and the refinement of an electronic system for gathering data on the types and volume of patients seen by students in their third year. These efforts contributed to the School's success in earning a favorable review by the accrediting body.

"This is great news, indeed," said Dr. Atkinson.

MedEdPORTAL
Providing Online Resources To Advance Learning in Medical Education

By: Mary Spachek

Are you looking for inventive ways to get published? Have you developed lectures or seminars for medical students and residents? Here is a great way to gain recognition for your work in the wider medical education community and make it count for promotion and tenure. Submit your educational materials to MedEdPORTAL, a peer-reviewed online resource created by the Association of American Medical Colleges (AAMC).

The AAMC announced in April 2005 the launch of MedEdPORTAL, a Web-based tool that promotes collaboration across disciplines and institutions by facilitating the exchange of peer reviewed educational materials, knowledge, and solutions. MedEdPORTAL will serve as a central repository of high quality educational materials such as PowerPoint presentations, assessment materials, virtual patient cases, and faculty development materials.

MedEdPORTAL will be implemented in three phases through 2005 and 2006. During Phase I (March-November 2005) non-Web-based educational materials and those that are available on external Web sites, will be peer-reviewed, referenced, and linked on the MedEdPORTAL site. Faculty may submit their Web sites or educational materials at anytime for peer review and if accepted, the resources will be referenced in the MedEdPORTAL system as a peer reviewed resource.

In Phase II (November 2005 - November 2006), a new database will replace the current Cube application and users will be able to search the database using keywords.

In Phase III (November 2006) the final MedEdPORTAL database will host the actual resources and authors will be able to download resources. The MedEdPORTAL Web address is www.aamc.org/mededportal

Individuals interested in submitting educational materials for peer review can review the peer review guidelines and download the submission form from the following MedEdPORTAL Web page: www.aamc.org/meded/mededportal/publish.htm

Mental Health Care Crisis Brewing for Kansas

By: Sheldon H. Preskorn, MD, *Professor and Chair*

Crises can be like hurricanes: predictable, imminent but not yet on shore. When they hit, they can devastate a community that has not adequately reinforced its safety precautions.

Kansas has its equivalent of Hurricane Katrina ready to hit its psychiatric inpatient health care system. As with Katrina, there have been warnings such as the recent "F" that Kansas got on its provision of psychiatric medical care for Kansans. However, that report, while bad, did not begin to contemplate the potential inpatient crisis brewing for central Kansans. In the event that the current fragile system collapses, the consequences will affect every Kansan, either directly or indirectly, just like the collapse of the levees affected every citizen in New Orleans.

The problem is: The Kansas approach to psychiatric medical services is based on 1890s and 1960s thinking. The 1890s component of the current system is the large state psychiatric hospitals located on the prairie removed from large urban populations. The 1960s component is the closure or downsizing of those facilities and replacing them with mental health clinics (MHC). While these approaches made some sense in their day, the system has not kept up with reality largely due to a failure of our elected officials to keep abreast of the times and to plan appropriately.

To put the current system in perspective, consider how the current mental health system would work if applied to any other major medical problem. In this system, the health system is divided into two components: (a) outpatient clinics (e.g., MHC) in the urban areas, and (b) inpatient services remote from the largest urban populations, particularly the Metropolitan Statistical Area of Sedgwick County with its approximately 600,000 Kansans. If you are reasonably healthy, this system works OK, but when you get ill and need inpatient care, you will have to be transported miles from where you live.

Consider that you have just had a heart attack. You are loaded into an ambulance and transported 150 miles away for your inpatient care. Would we tolerate such a system for our loved ones who suffered a heart attack? I don't think so. Yet, that is what looms for our loved ones who have suffered a serious acute exacerbation of a psychiatric illness.

Some will say: That isn't the case now – the person in Sedgwick County can be taken to Via Christi. For now that is true. However, it may not remain true if the current problems are not soon addressed as outlined below.

In 1990, there were seven inpatient services in Sedgwick County, with more than 350 beds. Today, there is one, the Via Christi inpatient psychiatric facility, with about 100 beds. Unfortunately, this reduction is not due to tremendous advances making inpatient psychiatric care outmoded. While advances in psychiatric care have been made, they have not been sufficient to account for this decrease in inpatient facilities. Instead, the loss of these inpatient psychiatric facilities has been due to money. The funding for such care has steadily eroded over the last 15 years. More and more citizens in general are uninsured, and that is particularly true for those with psychiatric illnesses because these illnesses are the greatest cause of social disability. The inability to get adequate care leads to an increase in disability, dysfunctional families, homelessness, substance abuse, and suicide.

While the uninsured are growing, the state has been closing state hospitals and downsizing beds in the state facilities that have remained open. At the same time, the state has failed to provide funding to private community hospitals such as Via Christi which provide needed inpatient psychiatric care to the indigent. While those community hospitals, to their credit, have picked up the slack in needed services, they have in doing so enabled the state to be dysfunctional in terms of the provision of an appropriate system for psychiatric health care.

The problem is that Via Christi and other such private community hospitals have to meet their budgets. These hospitals have reported substantial losses for their psychiatric inpatient service over the decade. For this reason, their financial ability to continue to provide such services appears precarious.

They are not alone. Private psychiatric health care providers have also found it financially difficult to provide inpatient psychiatric services. For this reason, 85% of the psychiatric inpatients in Sedgwick County are cared for by either the KUSM-W Department of Psychiatry and Behavioral Sciences through its teaching services or through COMCARE (the community mental health care clinic for Sedgwick County) inpatient service.

This situation first reached a crisis eight years ago when the number of psychiatrists available for the unassigned service in Sedgwick County was no longer sufficient to meet the need. As a result, the KUSM-W Department of Psychiatry and Behavioral Sciences took over this service completely. However, the mission of the department is the education of medical students and residents and not the provision of unlimited, unassigned inpatient services. Nevertheless, the department recognized the need and the distinct possibility that the Via Christi inpatient service might be unable to continue without the department stepping up in this manner.

The department thus knows first hand the problems with unfunded care, receiving only 23 cents for every dollar of services rendered to citizens of central Kansas, and that 23 cents is before the billing expenses are taken out. Removing those expenses, the department receives about 10 cents for every dollar billed. One does not have to be an astute business person to realize that is not a sustainable model.

So what if Sedgwick County had no inpatient psychiatric facility? That means most citizens of this region of Kansas would have to be transported 150 miles away to either Larned or Osawatomie State Hospital. However, those hospitals are not able to provide the level of care currently provided in Sedgwick County because they are not near a major full-fledged medical center with advanced imaging and other diagnostic tests. After all, the psychiatric emergencies are sometimes due to an unrecognized general medical condition such as a brain tumor.

The alternatives to transporting to state hospitals would be incarceration (a return to the 18th century approach to psychiatric service delivery) or on the streets or the cemetery. In fact, all of those happen today.

The transportation to state hospitals 150 miles away will have multiple serious implications:

- It will separate the patient and their families.
- It will place a substantial burden on the district attorney's office, the district court, and the sheriff's department in the case of involuntary patients, and on the ambulance services for the rest.
- The transition between inpatient stay and outpatient follow-up will be complicated with a significant likelihood for patients dropping through the gaps between the inpatient and the outpatient providers. That will predictably lead to increased relapse, increased cost and strain on all involved and poorer outcomes for patients, their families, and the state as a whole.

The above problems already exist to a serious degree but will be substantially amplified in the scenario of no inpatient psychiatric facility in Sedgwick County. Some may wonder about the ability of Prairie View to fill this role. While that facility provides needed services, it is a free standing psychiatric facility that can not provide the level of care currently provided in Sedgwick County and is often full even now.

Who is to blame for this situation? Every one of us is responsible. It begins with every citizen who has either passively or actively allowed this situation to develop. Also responsible are our elected and appointed officials, including the Sedgwick County commissioners and City of Wichita commissioners, the county and city managers, our state legislatures, and our governors. Parenthetically, that is not just the elected and appointed officials of today but those over the last 15-20 years since this situation has been festering and growing over that period. It also includes everyone who through their good intentions has enabled this fragile and probably unsustainable system to develop.

What needs to happen? To take the first step into the 21st century in terms of its provision of psychiatric services, the state needs to support inpatient beds in urban centers for its citizens suffering from acute exacerbations of psychiatric illnesses but with no means to pay for them.

So why have we not developed a better plan? As usual, they are mainly economic. First, the possibility of putting state inpatients beds in urban centers immediately raises the concern about the closure of the existing state hospitals which have been in their small communities for over 100 years and which are considered vital to the economic base of those communities. However, closure of those facilities is not the necessary outcome for the following reasons:

1. There are plenty of small communities in Kansas which are not large enough to have state beds. For these communities, the two existing state hospitals will remain the place where such care is delivered.

2. The state beds in urban centers will be for those individuals who only need short lengths of stay (14 days or less) to resolve their acute illness or acute exacerbations of their chronic illness. Patients who need longer inpatient treatment will be transported to the state hospital when that decision is made.

In this plan, the urban psychiatric state beds will provide acute care in the community for the large number of patients who do not need more than a few days in the hospital to resolve the acute exacerbation. Those who need longer care will be transported to the large but remote state hospitals as is done now.

A second objection is that the knee jerk reaction that this plan means that the state would have to invest in bricks and mortars in urban centers such as Sedgwick County to build such state inpatient facilities. That is also not true. Community facilities such as the Via Christi inpatient psychiatric unit already exist but are underfunded under the current model. Rather than building a state facility, the state could contract with these existing facilities for a specific number of beds as well as with psychiatric physicians to manage these patients.

The time for action is now. Kansas is waiting for its Katrina to hit. Further delays will only make it more likely that the crisis will occur. The question is: Will the leaders in Wichita and Kansas be like their counterparts in New Orleans and Louisiana or will they take needed action now to protect their citizens and their communities. Time will tell.