Southern California

PSYCHIATRIST

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President's Column

Bipolar Depression and the Waning Days of Summer

David Fogelson, M.D.

We arrived in Anchorage on July 30th and at half past midnight (I peeked out from the black out curtains) the next morning the sun was setting. The sun rose at 4:00 (by then I was fast asleep). In an eerily prescient moment, I thought about Robin Williams' starring role in the film, Insomnia, which in part revolves around the disorienting effects of perpetual daylight of the Alaskan summer. I did not imagine that a week later I would be reading that he had taken his own life. Another reminder of the terrible mortality associated with the illnesses we treat came the next day. We had flown to a remote wilderness lodge. The guide was talking about white water kayaking in Alaska. He showed me a classic book about the subject written by one of my medical school classmates. He told me how saddened mountaineers and kayakers had been when they learned that this doctor had committed suicide. All around me were reminders that we are entrusted with the lives of our patients and that the diseases we treat pose a mortal threat to our patients, as much, if not more than diseases treated by specialists in other branches of internal medicine.

One of the most challenging clinical problems we face is the treatment of Bipolar Depression. Untreated Bipolar Depression has a 15% mortality rate due to suicide. There has been considerable controversy about the best way to treat Bipolar Depression. Should antidepressants ever be prescribed to a Bipolar patient? Do antidepressants cause agitated mania? Do they cause cycle acceleration? In a recent issue of the American Journal of Psychiatry (a subscription to which is a benefit of membership in the APA), The International Society for Bipolar Disorders (ISBD) Task Force Report on Antidepressant Use in Bipolar Disorders was published (Am J Psychiatry 170:11, November 2013) and weighed in on this controversy. This report attempts to combine evidence based treatment algorithms with expert consensus. I present a summary of their findings and consensus statements in the hope it will enhance our treatment of Bipolar Depression.

SUMMARY OF FINDINGS

♦Acute Treatment

♦Adjunctive Antidepressants may be useful for acute Bipolar I or II depressive episodes when there is a history of previous response

♦Adjunctive Antidepressants should be avoided for depression with two or more co-occurring manic symptoms or psychomotor agitation or a history of rapid cycling

♦Maintenance Treatment

♦Consider maintenance treatment if

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depressive relapse occurs off antidepressant

♦**Monotherapy**

♦Antidepressant Monotherapy should be avoided in BPI depression

♦Antidepressant Monotherapy should be avoided in BPI & II depression with two or more co-occurring manic symptoms

♦**Switch to mania, hypomania, mixed states, or rapid cycling**

♦Bipolar patients starting antidepressants must be closely monitored for mania and agitation

♦Discontinue antidepressants if signs of mania occur

♦Discourage antidepressant if there is a history of antidepressant induced mania/agitation

♦Avoid antidepressants in patients with history of rapid cycling

♦**Use in Mixed States**

♦Avoid antidepressant prescription in patients with predominantly mixed states

♦Avoid antidepressants in mania/depression with mixed features

♦Discontinue antidepressants if patient is currently in a mixed state

♦**Drug Class**

♦Adjunctive treatment with SNRIs or tri- or tetracyclic antidepressants are second line after other treatments have failed

♦SNRIs and tri-or tetracyclic antidepressants must be closely monitored because of increased risk for switching or destabilization

Based upon this summary of the literature they came up with the following consensus statements about the usage of antidepressants in the treatment of Bipolar Depression:

♦1. Non-antidepressants should be considered as monotherapy for depression before Rx antidepressants
- ♦Lithium
- ♦Lamotrigine
- ♦Olanzapine
- ♦Quetiapine
- ♦Lurasidone

♦2. If antidepressants are prescribed in Bipolar I Disorder they should be prescribed with a mood stabilizer
- ♦This recommendation is made even though evidence is mixed for antidepressant induced mood switching
- ♦And even though the ability of mood stabilizers to prevent switching is unproven

♦3. Antidepressants in acute depression in Bipolar II Disorder are relatively well tolerated but may or may not be effective

♦4. Long term prophylactic value is poorly studied in BP I &II

♦5. There is little evidence to support one antidepressant being more or less effective or more or less dangerous
- ♦Exceptions are tri- and tetracyclics and venlafaxine, which carry high risk for inducing elevated mood states

♦6. Antidepressants can neither be condemned nor endorsed without consideration of each unique clinical case & presentation

In the news are encouraging reports of more and more jurisdictions adopting Laura's law. Laura's Law allows California's counties to provide programs of intensive, court-ordered treatment in the community for individuals with mental illness who are, because of symptoms of their illness, least able to otherwise obtain timely intervention. Laura's Law will:

• Permit people who are severely disabled by mental illness—and currently caught in a revolving door of homelessness, incarceration, and hospitalization—to receive timely, continuous, and supervised treatment in the community.

• Safeguard the public and the person, by allowing families and mental health professionals to petition for "assisted outpatient treatment" for individuals incapacitated by mental illness before they become a danger to themselves or others.

• Protect the rights of the individual by requiring court approval of the petition to provide "assisted outpatient treat-

ment" to assure that it is applied only to those who are so severely disabled by mental illness that they are unable to stay in treatment without help and supervision.
• Authorize "assisted outpatient treatment" orders lasting up to 180 days and, when appropriate, the renewal of them.
• Provide those under orders with intensive, supervised mental health treatment in the community until they are capable of maintaining their own psychiatric care and recovery.
• Reduce county expenditures on law enforcement interaction, judicial, jail,
and crisis services.
• Services may be paid for through MHSA funds.

Activities on calendar of note in our region:

California Psychiatric Association
27th Annual Premier Conference
September 19-21, 2014
Tenaya Lodge, Yosemite, California
14 hours of CME offered in a spectacular setting
Go to CPA website for details

9/28 in Redondo Beach, the Art of Psychiatric Medicine Project 2—Life as a Song, see SCPS newsletter for details.

Psychopharm Update 26 is scheduled for January 31, 2015—-so a notice for readers to save the date.

Finally, we will be sending electronic dues statements in an effort to reduce paper waste and to reduce our mailing costs. Please look for the statement in your in box.

Enjoy the waning days of summer. Look forward to catching up with all of you this fall!

Letter from the Editor

Good IDEA Gone Wrong?

Colleen Copelan, M.D.

Those of us who treat children and adolescents have noticed that in recent years school districts—some districts more than others—are increasingly likely to deny mental health services for their most troubled students.

The federal Individuals with Disabilities Education Act (IDEA) provides funding to states to assist disabled children to access their due Free and Adequate Public Education. The Act gives rise to the familiar Individual Education Plan (IEP) for affected students and may range from inexpensive accommodations to more costly residential treatment.

Because schools were reluctant to discover trouble they would have to pay for, California passed legislation (AB 3632) to assign assessment responsibilities to county mental health departments. State funding for those programs dried up and the responsibility ended three years ago when the state began sending the money, $420M, directly to the schools, just like before AB 3632. Giving schools the money to use as they

see fit, just like before AB 3632.

Now, it can certainly be argued—and it is--that schools are wise to use their newly re-acquired money for broad-based and local services but it seems—in some districts more than others—that this new focus profits from denying more expensive care for the more troubled youth.

Therapeutic school and residential placements have plummeted and hospitalizations and suicide attempts have risen. Parents' appeals to administrative law judges have nearly doubled.

Jocelyn Wiener, an investigative reporter with the USC Anneberg Center, has written a wonderful piece on this topic, recently published in the Sacramento Bee. It was long and hard work bringing the pieces together because, strange as it seems, nobody keeps track of what exactly happens when funding streams change course. cocopelan@aol.com

Save the Date
January 31, 2015
Psychopharmacology Update 26

Speakers:
Joseph Goldberg, M.D.
Paul Summergrad, M.D.
Gerald Maguire, M.D.
Itai Danovitch, M.D.
Joel Yager, M.D.

A grant from SCPS helped sponsor a welcoming event for the twelve new USC residents at Nick and Stef in downtown LA.

Each year the Southern California Psychiatric Society invites its non-dues paying Life Members, Life Fellows, and Life Distinguished Fellows to make a voluntary dues contribution. We are lucky to have such generous dues exempt members and thank them for their gracious contributions:

David Bender, M.D.
Michael Blumenfield, M.D.
Daniel Borenstein, M.D.
Rafael Canton, M.D.
Walter Chameides, M.D.
Thomas Ciesla, M.D.
Ned Cowan, M.D.
Raymond Friedman, M.D.
Marcia Goin, M.D.
Roderic Gorney, M.D.
Richard Greenberg, M.D.
Michela Gunn, M.D.
Neil Haas, M.D.
Dolores Hernandez, M.D.
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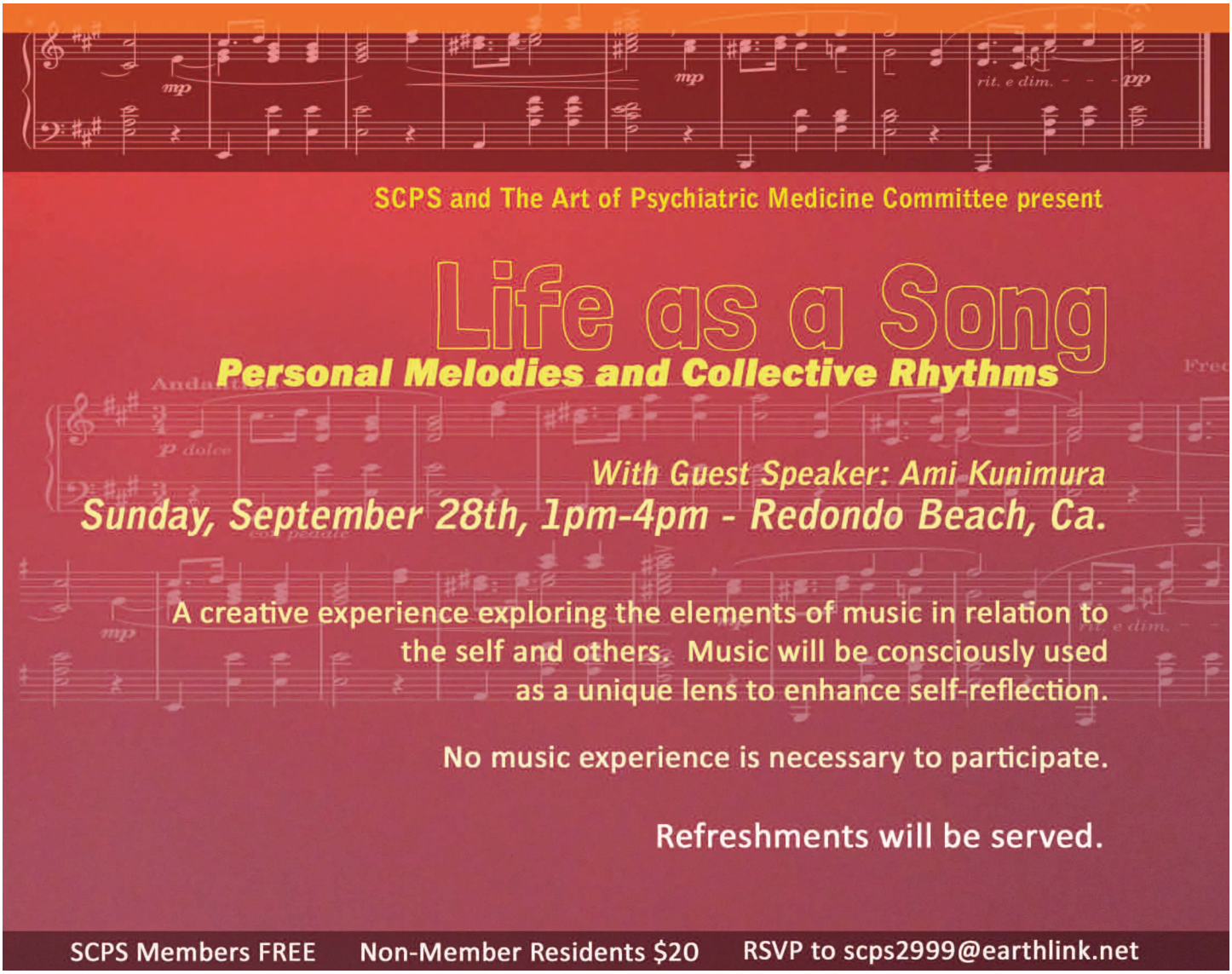
Nancy Rosser, M.D.
Robert Rubin, M.D.
Alberta Samuelson, M.D.
Ernest Schreiber, M.D.
Irwin Schultz, M.D.
Jerald Simon, M.D.
James Teague, M.D.
Ronald Thurston, M.D.
John Wells, M.D.
Samuel Wilson, M.D.



JOIN YOUR COLLEAGUES !!!

California Psychiatric Association
27th Annual Premier Conference
September 19-21, 2014
Tenaya Lodge, Yosemite, California

For an outstanding scientific program, legislative update and collegial gathering at the Tenaya Lodge in Yosemite, CA

http://www.calpsych.org/annualmeeting2014.html

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LAC DMH
LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

HOPE WELLNESS RECOVERY

Help Build healthcare's Future

Psychiatrist Job Overview

The Los Angeles County Department of Mental Health is seeking dedicated psychiatrists to join our multi-disciplinary treatment teams. Our Department is part of a dynamic healthcare system that is rapidly evolving to meet the needs of the largest county in the United States. National healthcare reform and California's innovative Mental Health Services Act have provided us with the resources to create cutting-edge programs and technologies. The Department of Mental Health serves a culturally diverse population of all ages and offers opportunities for career advancement and a wide range of work settings.

Salaries and Benefits

- Salaries up to the mid $200,000s
- Board Certification bonus
- Site bonus for Jail and Juvenile Justice work assignment
- Exceptional benefits package including 11 paid holidays, vacation, and sick leave
- Generous retirement benefits
- 80 hours annually paid for CME training
- Outside employment allowed up to 24 hours weekly

To receive information about employment as a psychiatrist at the Los Angeles County Department of Mental Health please visit

www.psychiatristjobs.la

Roderick Shaner, M.D.
Medical Director
Los Angeles Department of Mental Health
550 S. Vermont Avenue, 12th Floor
Los Angeles, CA 90020

CLASSIFIEDS

Positions Available

Psychiatrist needed 1-2 days per week for small mental health clinic in Corona. Time is flexible to accommodate Doctor's schedule. Most of our clients are children receiving MediCal, some in foster care. More hours available as the clinic grows. Contact clinic director, Elliot Horowitz MFT at 951-735-5300 or 949-350-8395.

Space Available

Furnished 6th floor penthouse office overlooking the Valley in Van Nuys bordering Encino & Sherman Oaks. Large waiting room, kitchen. Easy access 405/101 on Sepulveda Blvd. $450 for 30% time, $600 for 50%. No hourly! Referrals available. Also have small interior office, 64 square feet, no windows $280. Both available October 1. Contact ter.schneider@att.net.

ALL EDITORIAL MATERIALS TO BE CONSIDERED FOR PUBLICATION IN THE NEWSLETTER MUST BE RECEIVED BY SCPS NO LATER THAN THE 5TH OF THE PRECEDING MONTH. NO AUGUST PUBLICATION. ALL PAID ADVERTISEMENTS AND PRESS RELEASES MUST BE RECEIVED NO LATER THAN THE 5TH OF THE PRECEDING MONTH.

SCPS website address: www.socalpsych.org

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