DCF Psychotropic Medication Advisory Committee
Monthly Meeting Notes
November 7, 2007, 1:00 PM
Riverview Hospital for Children and Youth
Middletown, CT

PRESENT: Janet Williams, MD, DCF Medical Director; Lesley Siegel, MD, DCF Regional Medical Director; Jacqueline Harris, MD, DCF Regional Medical Director; Joan Narad, MD, Associate Medical Director, RVH; M. Waqar Azeem, MD, RVH Medical Director; Milind Kale, MD, CJTS; John Pitegoff, MD; CCP Pediatrician; Brian Keyes, MD, NAFI: Aurele Kamm, APRN, CMCU Coordinator; Curtis Harmon, APRN, CMCU; MaryAnn D'Addario, DCF Director of Nursing; Kris Ridyard, APRN, Willimantic DCF; Alton Allen, MD, RVH; Irv Jennings, MD, FCA; Marian Cancelliere, APRN, Waterbury DCF; Tina Spokes, RN, Hartford, DCF; Tina Renneisen, APRN, Yale; Beth Muller APRN, UCHC, Pieter Jost Van Wattum, MD, Medical Director, Clifford Beers.

1. Call to order: Janet Williams, MD called the meeting to order at 1:10 PM in the RVH AB Conference Room.
2. Set date/time of next meeting: The next meeting is scheduled for **December 7, 2007, 1:00 PM Riverview Hospital AB Conference Room.** Future meetings are as follows: January 4; February 1; March 7; April 4; May 2; June 6; July to be announced; August 1; September 5, October 3, November 7, December 5, 2008.
3. Announcements:
    a. Dr. Patricia Leebens will be presenting on the Behavioral Health Care of Foster Children in North Haven on November 8, 2007.
    b. Dr. Williams was very pleased to announce that Joan Narad, MD, has accepted the position of Regional Medical Director, Eastern Region, to begin in January, 2008.
    c. Dr. Williams announced that the deadline for RFP submissions for pharmaceutical services for this committee is next week. So far two companies have expressed interest; one from out of state, and Dave Aresco's group. Drs. Pieter Jost Van Wattum, and Brian Keyes, plus Curtis Harmon, APRN, volunteer to be part of the committee reviewing the RFPs.
    d. Dr. Williams announced that she has asked Dr. Plant to attend a future meeting, most likely not December due to absences, as requested by Dr. Jennings in the October meeting to be able to talk about medication use in less structured environments such as PDCs or Safe Homes.
4. Minutes: The minutes of the October 5, 2007 meeting were accepted with minor changes.
5. Update- Centralized Medication Approval Process: Committee members were very enthusiastic about the new process. Tina Spokes added that she has 4

boxes of psychotropic medication files on Hartford patients that she would like to move to CO.

6. Review of PMAC Bylaws:
    a. The last line of the "Composition" section was changed so that CV's would only be required for non-state employees.
    b. The second point of the "Organization" section was changed so that a quorum will only be required for voting.
    c. Dr. Williams announced that Beverly Ramsey will be joining this committee as a parent advocate. Ms. Ramsey is a parent and member of AFCAMP, which is a subgroup of FAVOR.
    d. Dr. Williams stated that the membership of this committee will be ratified at the December meeting.
7. Update on Research Proposal:
    a. Dr. Williams announced that DCF and DSS lawyers are currently examining whether there needs to be a new MOU between the two agencies or whether the current MOU is sufficient for exchanging the data needed for this study.
    b. Drs. Williams and Van Wattum distributed the findings from a poster presentation at the Academy by Zito, Safer, et.al on psychotropic medication patterns among foster youth in Texas. In this study 32,135 Texas youth, age 0-19, who were Medicaid foster care enrollees from 9/2003-8/2004 were studied. ("foster care" wasn't defined, and it was unclear whether group living situations were included). Of these, 12,189 had a dispensed psychotropic medication amounting to an annual prevalence of 37.9%. A random sample of 472 youth received at least one psychotropic were selected. Of these, 72% received 2 or more psychotropics from difference classes; 41.3% received 3 or more, and 15 % received four or more; 93% of the prescribing was by psychiatrists. 56% were on antidepressants; 53% were on antipsychotics; and 55.9% were on ADHD meds. Dr. Pitegoff pointed out that 65% were on DDAVP, despite there being no research to suggest this is useful except for when there's a concentrating deficit in the renal tubules. (*As an aside, Dr. Pitegoff suggested that patients be referred to CCMC's "dysfunctional voicing service" instead of prescribing DDAVP).* Dr. Williams indicated that she would contact Dr. Zito for follow-up.
8. Update on Psychopharmacologic Issues from the October AACAP Meetings:
    a. Dr. Williams presented findings from a workshop she attended by Melissa DelBello, MD, MS; from the University of Cincinnati, titled: Pharmacological Treatment of Youth with Bipolar Disorder: An Update. The points from this presentation she wanted to relay to this committee were as follows:
        i. In an article she recently published in the Am. J. Psychiatry 2007 (which was distributed at this meeting) 2/3's of first-episode bipolar adolescents to not continue their medications.

Predictors of non-compliance include ADHD, low SES, and EtoH use.

ii. When reviewing all double-blind studies for manic or mixed episodes in bipolar youth, there is no data on lithium, despite being FDA approved; the data on divalproex is negative, and the data on topiramate is +/-. Only atypical antipsychotics have positive double-blind study results.

iii. Oxcarbazepine has not been shown to be effective for pediatric mania, although in one study by Karen Dineen Wagner from the AmJPsych July 2006 (distributed) Dr. Delbello said the numbers were better for younger patients (although this committee's review showed that while 41% of children responded compared to 17% of controls vs. 43 % of adolescents vs. 40 % of controls, the drop-out rate was very large, and its not clear either group was statistically significant).

iv. The one double-blind study on topiramate was ended because of lack of efficacy.

v. The group discussed that fact that some CT child psychiatrists still like to prescribe topiramate because they feel its effective and it can cause weight loss. However, others pointed out that 25% get cognitive dulling, which can occur even at low doses and is a significant problem in this population which has a low average IQ to begin with.

vi. This Risperidone study (like many others) showed that there were no advantages about 2.5 mg/day.

vii. The Quetiapine study showed no advantages when doses of 600 mg/day were compared to 400 mg/day (although it was only a 3 week study).

viii. Dr. Pieter Jost Van Wattum pointed out that Aripiprazole has been studied for 30 weeks in mania and it is well tolerated and effective (although low dose-i.e. 5 mg. was not studied, while high doses can be sedating).

ix. An 8 week open label study of lamotrigine showed some response between 100-200 mg/day.

x. Recommended dosing of atypical antipsychotics for pediatric BP was as follows: Olanzapine 10-20; Risperidone .5-^{n}.5; Quetiapine 400-600, Ziprasidone 80-160, and Aripiprazole 10-30.

xi. The reports on maintenance treatment were discouraging- more than 80% relapse within 2 years.

xii. Dr. Van Wattum reported that at a poster presentation reported that if family chaos is present, then meds didn't work as well….?were the patients compliant??were parents bipolar?? Was the increased stress in the home related to med's non-effectiveness?

xiii. Dr. Williams referred everyone to the excellent article in JAACAP 2006 by Correll and Carlson which had a table on strategies for the prevention and management of weight gain and metabolic abnormalities.

b. Dr. VanWattum presented findings from a large multi-site, open-label study by DelBello, Wagner, Wilens, Kowatch, and others on treatment of acute mania with Depakote ER in 160 children ages 10-17. This study included a 30 weeks follow-up. The average dose was 19.5 mg/kg with levels of 80-125. The conclusion was that Depakote was well tolerated but didn't work.
c. Dr. Narad, who also attended the AACAP meetings, pointed out that in past years "irritability" was used as one of the hallmarks for the diagnosis of pediatric bipolar disorder. However, she now has noticed a trend away from regarding this as a defining symptom.
d. Dr. Van Watum reviewed the recent article in AMJPsychiatry (October 2007) on Olanzapine vs. Placebo in the treatment of adolescents with bipolar mania. In this 3 week double blind study, patients gained an average of 3.1 kg, and in the 28 week follow-up they gained an average of 7.2 kg, with outliers gaining up to 30 pounds. While their conclusion was that olanzapine was effective, the side effects (wt. gain plus increased LFTs, increased uric acid, etc.) were significant.
e. Dr. Siegel asked whether this committee should consider taking divalproex off the list of approved medications for treatment of bipolar disorder, given that we have taken off topiramate and oxycarbazepine for a similar lack of evidence. Dr. Azeem pointed out that Dr. Steiner has found divalproex to be effective for treatment of aggression in juveniles in detention. Dr. Azeem also pointed out DCF has a distinctly different population, most of whom would be ineligible for the studies reviewed today. All agreed that the jury is still out whether these medications might be helpful for the treatment of aggression/emotional lability in traumatized youth.
f. In a discussion related to side effects of medications, Dr. Pitegoff pointed out that while Lithium often causes hypothyroidism, which is easily treated with replacement therapy, once a patient stops Lithium physicians generally continue the thyroid replacement without evaluating whether the thyroid functioning has returned to baseline. At CCP he has been able to take some patients off levothyroxine with good success.

9. <u>Other</u>
   a. Related to points made about side effects to medications, Dr. Williams suggested sponsoring a conference between CCACP, APRNs (Beth Mueller said there's a website which lists the Child APRNS), and Connecticut Pediatricians (Ron Angoff is President of their Council).

Dr. Azeem said that the AACAP has funding for collaboration. Dr. Williams said she would suggest this when she attends their Board meeting later this month. Dr. Pitegoff also suggested contacting Dr. Namerow about using a CCMC Grand Rounds time.

b. Dr. Williams distributed the latest copy of the Child and Adolescent Psychopharmacology News, edited by Stanley Kutcher, MD. She highlighted the following points:
    i. There is an excellent section on Polypharmacy with 8 practice points. The suggestion was made to place this on the DCF Website.
    ii. An article summarizes the Archives of General Psychiatry 2007 paper by Scherk, et. al. which describes a meta-analysis of 24 studies comparing efficacy and safety of SGA (second-generation antipsychotics) monotherapy vs. placebao; SGA monotherapy vs. MS(mood stabilizer) monotherapy; MS monotherapy vs. SGA and MS combination; and SGA monotherapy vs. Haloperidol monotherapy. The outcome was that the combination of MS and SGA was superior to MS alone but not superior to Haloperidol for treatment of manic symptoms
    iii. A third article summarized the change in physician practice patterns regarding SSRI use since the FDA black box warning, and the parallel suicide rate rise in the USA, the first rise in over a decade. Dr. Keyes pointed out that the FDA recently withdrew their recommendation for weekly appointments for one month and then biweekly appointments for a second month after starting an SSRI. This decision was based on the lack of any scientific evidence regarding this timetable plus the potential increased liability if prescribers did not adhere to it.
c. Dr. Jennings ask that this committee consider the topic of "medical responsibility" (as opposed to "case responsibility" for patient care. Suggestions were made to invite Don Shevchuk to a future meeting and/or an APA or AACAP malpractice lawyer.
d. Dr. Pitegoff stated that he's heard from Dr. Leopold (head of pediatric cardiology at CCMC) that he's been flooded with EKGs given the new psychotropic medication monitoring, and that one can't pick up CV disease with an EKG alone. Dr. Siegel will invite Dr. Leopold to attend a future meeting.

10. Adjournment: Dr. Williams adjourned the meeting at 2:45 PM.

Respectfully submitted,

Lesley Siegel, MD
Director of Psychiatry, DCF
DCF Regional Medical Director, Southern Region