

Restoring to Competence a Case-by-Case Matter

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SEATTLE — Defendants who are incompetent to stand trial are less likely to be restored to competence with treatment if they are older or have dementia, according to study results reported at the annual meeting of the American Academy of Psychiatry and the Law. Still, roughly half of them achieve this goal.

The U.S. Supreme Court has ruled that defendants thought to be permanently incompetent to stand trial or unlikely to be restored in the foreseeable future must either be released or evaluated for civil commitment, Dr. Douglas R. Morris noted in an interview. But it remains difficult for treating psychiatrists to predict which incompetent defendants have little probability of restoration.

Dr. Morris and his colleagues searched

the Indiana forensic database for 1988-2004 to identify defendants hospitalized for treatment to restore competency to stand trial. They ascertained whether the defendants were restored to competence after 6 months (the state's statutory standard) and 1 year (the standard used in other states and published reports) and the clinical factors associated with restoration.

They identified 1,380 incompetent defendants. Some 3% had dementia, 2%

were older (at least 65 years) and did not have dementia, and 95% had other diagnoses or reasons for admission.

About one-third of patients in the dementia group had Alzheimer's disease, one-third had dementia not otherwise specified, and the remaining third had dementia because of vascular causes or substance use, said Dr. Morris, a psychiatrist at the University of South Carolina, Columbia. Overall, about one-quarter had comorbid psychotic disorders.

Mean age differed significantly across groups: It was 50 years in the dementia group, 72 years in the older group without dementia, and 35 years in the group with other diagnoses. More than 85% of the defendants were male, with no difference across groups. Those with dementia were significantly more likely to be white than were their counterparts with other diagnoses (72% vs. 57%).

After 6 months of treatment, the percentage of defendants who remained incompetent to stand trial was significantly higher in the dementia group (49%) and the older group (55%) than in the other-diagnoses group (26%), Dr. Morris said. The finding was similar after 1 year of treatment (36% and 32% vs. 15%).

The link between older age and a lower chance of restoration could be attributable to the impact of chronic mental illnesses, medical comorbidities, or both on cognitive function.

In a multivariate analysis adjusted for potential confounders (sex, race, treating hospital, psychotic disorder, mood disorder, and mental retardation), defendants with dementia were significantly less likely than were those with other diagnoses to be restored at 6 months (odds ratio 0.63) and at 1 year (OR 0.58).

The older defendants were on admission, the less likely they were to be restored to competence after adjustment for the above factors and dementia. The odds of restoration at 6 months were reduced by about 10% with a 5-year increment in age (OR 0.88) and by more than 50% with a 30-year increment (OR 0.46). Again, the findings were similar for restoration by 1 year (OR 0.85 and 0.36).

Dr. Morris said the link between older age and a decreased chance of restoration could be attributable to the impact of chronic mental illnesses, medical comorbidities, or both on cognitive function.

The link between dementia and reduced odds of restoration was not unexpected, he said, but it was noteworthy that almost half of demented defendants were restored to competence. Planned research might show which treatments and factors led to restoration in this group. In the end, "[prediction] will have to be done on a case-by-case basis—it will depend on the individual's specific deficits," he said.

Dr. Morris reported no conflicts of interest in association with the study. ■

Vyvanse™ (lisdexamfetamine dimesylate)

CII Rx Only

BRIEF SUMMARY: Consult the Full Prescribing Information for complete product information.

WARNING: POTENTIAL FOR ABUSE
AMPHETAMINES HAVE A HIGH POTENTIAL FOR ABUSE. ADMINISTRATION OF AMPHETAMINES FOR PROLONGED PERIODS OF TIME MAY LEAD TO DRUG DEPENDENCE. PARTICULAR ATTENTION SHOULD BE PAID TO THE POSSIBILITY OF SUBJECTS OBTAINING AMPHETAMINES FOR NON-THERAPEUTIC USE OR DISTRIBUTION TO OTHERS AND THE DRUGS SHOULD BE PRESCRIBED OR DISPENSED SPARINGLY. MISUSE OF AMPHETAMINES MAY CAUSE SUDDEN DEATH AND SERIOUS CARDIOVASCULAR ADVERSE EVENTS.

INDICATIONS AND USAGE

Vyvanse™ is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD). The efficacy of Vyvanse in the treatment of ADHD was established on the basis of two controlled trials in children aged 6 to 12 and one controlled trial in adults who met DSM-IV-TR® criteria for ADHD.

Vyvanse is indicated as an integral part of a total treatment program for ADHD that may include other measures (psychological, educational, social).

Long-Term Use

The effectiveness of Vyvanse for long-term use, i.e., for more than 4 weeks, has not been systematically evaluated in controlled trials. The physician should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

CONTRAINDICATIONS

Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity or idiosyncratic reaction to sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS AND PRECAUTIONS

Serious Cardiovascular Events

Sudden Death and Pre-existing Structural Cardiac Abnormalities or Other Serious Heart Problems: Children and Adolescents—Sudden death has been reported in association with CNS stimulant treatment at usual doses in children and adolescents with structural cardiac abnormalities or other serious heart problems. Although some serious heart problems alone carry an increased risk of sudden death, stimulant products generally should not be used in children or adolescents with known serious structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, or other serious cardiac problems that may place them at increased vulnerability to the sympathomimetic effects of a stimulant drug.

Adults—Sudden death, stroke, and myocardial infarction have been reported in adults taking stimulant drugs at usual doses for ADHD. Although the role of stimulants in these adult cases is unknown, adults have a greater likelihood than children of having serious structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, coronary artery disease, or other serious cardiac problems. Adults with such abnormalities should also generally not be treated with stimulant drugs.

Hypertension and Other Cardiovascular Conditions: Stimulant medications cause a modest increase in average blood pressure (about 2-4mm Hg) and average heart rate (about 3-6 bpm) and individuals may have larger increases. While the mean changes alone would not be expected to have short-term consequences, all patients should be monitored for larger changes in heart rate and blood pressure. Caution is indicated in treating patients whose underlying medical conditions might be compromised by increases in blood pressure or heart rate, e.g. those with pre-existing hypertension, heart failure, recent myocardial infarction, or ventricular arrhythmia.

Assessing Cardiovascular Status in Patients Being Treated with Stimulant Medications: Children, adolescents, or adults who are being considered for treatment with stimulant medications should have a careful history (including assessment for a family history of sudden death or ventricular arrhythmia) and physical exam to assess for the presence of cardiac disease, and should receive further cardiac evaluation if findings suggest such disease (e.g. electrocardiogram and echocardiogram). Patients who develop symptoms such as exertional chest pain, unexplained syncope, or other symptoms suggestive of cardiac disease during stimulant treatment should undergo a prompt cardiac evaluation.

Psychiatric Adverse Events

Pre-existing Psychosis: Administration of stimulants may exacerbate symptoms of behavior disturbance and thought disorder in patients with a pre-existing psychotic disorder.

Bipolar Illness: Particular care should be taken in using stimulants to treat ADHD in patients with comorbid bipolar disorder because of concern for possible induction of a mixed/manic episode in such patients. Prior to initiating treatment with a stimulant, patients with comorbid depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder. Such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder and depression.

Emergence of New Psychotic or Manic Symptoms: Treatment-emergent psychotic or manic symptoms, e.g. hallucinations, delusional thinking, or mania in children and adolescents without a prior history of psychotic illness or mania can be caused by stimulants at usual doses. If such symptoms occur consideration should be given to a possible causal role of the stimulant, and discontinuation of treatment may be appropriate. In a pooled analysis of multiple short-term, placebo-controlled studies, such symptoms occurred in about 0.1% (4 patients with events out of 3482 exposed to methylphenidate or amphetamine for several weeks at usual doses) or stimulant-treated patients compared to 0 in placebo-treated patients.

Aggression: Aggressive behavior or hostility is often observed in children and adolescents with ADHD, and has been reported in clinical trials and the post marketing experience of some medications indicated for the treatment of ADHD. Although there is no systematic evidence that stimulants cause aggressive behavior or hostility, patients beginning treatment of ADHD should be monitored for the appearance of, or worsening of, aggressive behavior or hostility.

Seizures

There is some clinical evidence that stimulants may lower the convulsive threshold in patients with prior history of seizures, in patients with prior EEG abnormalities in absence of seizures, and, very rarely, in patients without a history of seizures and no prior EEG evidence of seizures. In the presence of seizures, the drug should be discontinued.

Visual Disturbance

Difficulties with accommodation and blurring of vision have been reported with stimulant treatment.

Tics

Amphetamines have been reported to exacerbate motor and phonic tics and Tourette's syndrome. Therefore, clinical evaluation for tics and Tourette's syndrome should precede use of stimulant medications.

Long-Term Suppression of Growth

Careful follow-up for weight in children ages 6 to 12 years who received Vyvanse over 12 months suggests that consistently medicated children (i.e. treatment for 7 days per week throughout the year) have a slowing in growth rate, measured by body weight as demonstrated by an age- and sex-normalized mean change from baseline in percentile, of -13.4 over 1 year (average percentile at baseline and 12 months, were 60.6 and 47.2, respectively). Therefore growth should be monitored during treatment with stimulants, and patients who are not growing or gaining weight as expected may need to have their treatment interrupted.

Prescribing and Dispensing

The least amount of amphetamine feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Vyvanse should be used with caution in patients who use other sympathomimetic drugs.

ADVERSE REACTIONS

Clinical Studies Experience

The premarketing development program for Vyvanse included exposures in a total of 762 participants in clinical trials (348 pediatric patients, 358 adult patients and 56 healthy adult subjects).

In the controlled pediatric (aged 6 to 12) trial, 10% (21/218) of Vyvanse-treated patients discontinued due to adverse reactions compared to 1% (1/72) who received placebo. The most frequent adverse events leading to discontinuation and considered to be drug-related (i.e. leading to discontinuation in at least 1% of Vyvanse-treated patients and at a rate at least twice that of placebo) were ECG voltage criteria for ventricular hypertrophy, tic, vomiting, psychomotor hyperactivity, insomnia, and rash (2/218 each; 1%). The most common adverse reactions (incidence \geq 5% and at a rate at least twice placebo) were decreased appetite, dizziness, dry mouth, irritability, insomnia, upper abdominal pain, nausea, vomiting and decreased weight.

In the controlled adult trial, 6% (21/358) of Vyvanse-treated patients discontinued due to adverse events compared to 2% (1/62) who received placebo. The most frequent adverse events leading to discontinuation and considered to be drug-related (i.e. leading to discontinuation in at least 1% of Vyvanse-treated patients and at a rate at least twice that of placebo) were insomnia (8/358; 2%), tachycardia (3/358; 1%), irritability (2/358; 1%), hypertension (4/358; 1%), headache (2/358; 1%), anxiety (2/358; 1%), and dyspnea (3/358; 1%). The most common adverse reactions (incidence \geq 5% and at a rate at least twice placebo) were upper abdominal pain, diarrhea, nausea, fatigue, feeling jittery, irritability, anorexia, decreased appetite, headaches, anxiety and insomnia.

Postmarketing Reports

The following adverse reactions have been identified during post approval use of Vyvanse.

Cardiac Disorders: Palpitation

Eye Disorders: Vision blurred, mydriasis

Immune System Disorders: Hypersensitivity

Nervous System Disorders: Seizure, dyskinesia

Psychiatric Disorder: Psychotic episodes, mania, hallucination, depression, aggression, dysphoria, euphoria, logorrhea

Skin and Subcutaneous Tissue Disorder: Angioedema, urticaria

USE IN SPECIFIC POPULATIONS

Pregnancy: Pregnancy Category C. Amphetamines should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Amphetamines are excreted in human milk. Mothers taking amphetamines should be advised to refrain from nursing.

Pediatric Use: Vyvanse has not been studied in children under 6 years of age or adolescents. Amphetamines are not recommended for use in children under 3 years of age.

Geriatric Use: Vyvanse has not been studied in the geriatric population.

DRUG ABUSE AND DEPENDENCE

Vyvanse is classified as a Schedule II controlled substance.

OVERDOSAGE

Toxic symptoms may occur idiosyncratically at low doses. Treatment: Consult with a Certified Poison Control Center for up-to-date guidance and advice. The prolonged release of Vyvanse in the body should be considered when treating patients with overdose.

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