

The authors' disclosures appear with the original article.

This reply (doi: 10.1176/appi.ajp.2014.14010048r) was accepted for publication in April 2014.

Electroconvulsive Therapy is a Standard Treatment; Ketamine is Not (Yet)

TO THE EDITOR: Alan Schatzberg's commentary in the March issue, "A Word to the Wise About Ketamine" (1), urges caution in the clinical use of ketamine pending further research and data collection. We agree with this position and would like to share our clinical experience with seriously depressed patients who have received ketamine infusions prior to electroconvulsive therapy (ECT) referral. In the last year, we have seen at least half a dozen patients who, when they presented for ECT consultation, gave histories of having had either single or repeated ketamine infusions at a private anesthesiologist's office in New York City. These patients had either no, or very transient, antidepressant benefit from the ketamine or unpleasant adverse effects (mainly dissociative); they were subsequently referred by their psychiatrists for consideration of ECT. Most of these patients were profoundly depressed, and some were suicidal. If a ketamine challenge is to become a standard step in the treatment algorithm for treatment-resistant depression, the risks of not just the ketamine itself, but the delay in definitive treatment, must be taken into account.

Seriously depressed patients who have failed to respond to one or more antidepressant medication trials should be referred for ECT consultation, sooner rather than later, to ensure optimal outcomes. Suicide risk in this population is elevated, as is the potential for ongoing medical morbidity, not to mention the continued suffering from the depressive episode itself. A recent study (2) comparing three ketamine infusions with three ECT treatments in 1 week touted ketamine as a superior treatment and received considerable media attention (3). A reasonable interpretation of that research is that it replicated the finding of a signal of early antidepressant response with ketamine. However, ketamine remains completely unproven as a definitive treatment for a major depressive episode. Seriously ill psychiatric patients are often desperate for dramatic cures; their health care providers, acknowledging that our current treatments are often lacking, are also eager for the newest breakthroughs. Such desperation and enthusiasm should not cloud our clinical judgment; proven, evidence-based treatments, including ECT for seriously depressed patients, should be offered before unproven, experimental approaches, no matter how "in vogue" those approaches may be.

References

1. Schatzberg AF: A word to the wise about ketamine. *Am J Psychiatry* 2014; 171:262–264
2. Ghasemi M, Kazemi MH, Yoosefi A, Ghasemi A, Paragomi P, Amini H, Afzali MH: Rapid antidepressant effects of repeated doses of ketamine compared with electroconvulsive therapy in hospitalized patients with major depressive disorder. *Psychiatry Res* 2014; 215:355–361
3. Arehart-Treichel J: Ketamine outperforms ECT in depression study. *Psychiatr News*, Jan 2014, p 17

CHARLES H. KELLNER, M.D.
ROBERT M. GREENBERG, M.D.
GABRIELLA M. AHLE
LAUREN S. LIEBMAN

From the Department of Psychiatry, Icahn School of Medicine at Mount Sinai, New York, and the Department of Psychiatry, Lutheran Medical School, Brooklyn, New York.

Dr. Kellner receives grant support from NIMH, honoraria from the North Shore-LIJ Health System, UpToDate, and Psychiatric Times, and royalties from Cambridge University Press. Dr. Greenberg receives grant support from NIMH. The other authors report no financial relationships with commercial interests.

This letter (doi: 10.1176/appi.ajp.2014.14030354) was accepted for publication in April 2014.

Community Treatment for Violence in Released Inmates With Schizophrenia

TO THE EDITOR: The recent article by Keers et al. (1) on prisoners released to the community in England and Wales provides important research on the relationships between prisoners with serious mental illnesses, persecutory delusions, and violent incidents in the postrelease period. However, one of the conclusions reached by the authors does not seem supported by their data.

In their abstract, the authors conclude that "maintaining psychiatric treatment after release can substantially reduce violent recidivism among prisoners with schizophrenia." But the rates given in Table 2 of the article for violent incidents, during the period of study, are nearly identical for inmates with schizophrenia who received treatment during incarceration and then either stopped or continued treatment after release (27.3% and 24.5%, respectively). Both rates are significantly lower than for prisoners who received no treatment (50%).

A conclusion, based on this data, is that community follow-up in the postrelease period, which typically includes continuation of pharmacotherapy, counseling, and case management, has little effect in reducing violence for inmates with schizophrenia—provided they received treatment in prison. This is contrary to commonly held beliefs (2, 3) and merited some discussion.

A message to be taken from this study, which the authors did not comment upon, is that correctional mental health professionals have reason to be hopeful that the treatment they provide to their patients with schizophrenia during incarceration can reduce violent incidents after prison, even when treatment does not continue.

References

1. Keers R, Ullrich S, Destavola BL, Coid JW: Association of violence with emergence of persecutory delusions in untreated schizophrenia. *Am J Psychiatry* 2014; 171:332–339
2. Lamberti JS: Understanding and preventing criminal recidivism among adults with psychotic disorders. *Psychiatr Serv* 2007; 58: 773–781
3. Baillargeon J, Binswanger IA, Penn JV, Williams BA, Murray OJ: Psychiatric disorders and repeat incarcerations: the revolving prison door. *Am J Psychiatry* 2009; 166:103–109