Volume-4, Issue-3, March-2015 • ISSN No 2277 - 8160

Research Paper | Medical Science

Case Study: Mental Health Assessment & Treatment Plan

Dr Sangeetha Bobba MBBS FRACGP DCH CertSH&FPA GradCertMH

KEYWORDS :

Introduction

Mr. X, aged thirty-four is an Aboriginal man. Mr. X is currently in a long term homosexual relationship and lives with his partner. Mr. X has been diagnosed with schizophrenia and is HIV positive.

History of Presenting Complaint

On the morning prior to his presentation at the medical centre Mr. X attempted to take an overdose of his antipsychotic medication with the sudden intention of killing himself. He depicted the incident to be following "weird dreams" from the previous night the details of which he was unable to recall. Fortunately he was prevented from overdosing by his partner (Mr. Z, non-Aboriginal) who walked into the bedroom as Mr. X was "popping pills". It was noted that he had several different packets of medication on the bed including the antipsychotic medication he was taking (Quetiapine) and medications previously taken that were in the house, including Olanzapine and Chlorpromazine. Mr. X stated that he had not been hearing voices telling him to harm or kill himself (command auditory hallucinations) or any other symptoms of psychosis including hallucinations or possessing delusions.

Mr. X said that he felt "unsafe" at home as he would certainly try to kill himself by overdosing on his medication if he returned. As Mr. X expressed the ideation, intent and plan in addition to possessing the means to attempt suicide again his suicide risk was determined to be high. I called the ambulance and Mr. X was taken to hospital for admission.

Past Psychiatric History

Mr. X was diagnosed with paranoid schizophrenia in 1997 at the age of 19 years. He described the positive symptoms of his schizophrenia which included hallucinations (auditory, visual, gustatory, tactile and olfactory) and persecutory delusions which emerged at the age of 14 years. It is unknown whether the onset of his schizophrenia was abrupt or if he experienced a prolonged prodromal phase. He did not seek medical assistance until the age of 19 as his family's and cultural beliefs were that he was experiencing a "spiritual battle" which he had to "deal with" himself.

Since his diagnosis, Mr. X has experienced an average of three to four psychotic episodes each year. They are generally two weeks in duration, precipitated by his cannabis usage and always severe enough to warrant hospitalisation.

Mr. X has attempted suicide on multiple occasions in the past (he cannot recollect how many) with all but one incident associated with depression, occurring during his psychotic episodes. He emphasized that the voices he heard during psychotic episodes never commanded him to kill himself. He stated that he attempted to commit suicide to stop hearing the voices. Mr. X informed me that he has also overdosed on his medication "at least five times", all of which required hospitalization. These medications included Quetiapine, Olanzapine and Aripiprazole.

In addition, Mr. X has an extensive history of deliberate self harm (DSH). On questioning in regards to the number of such incidences he replied "I couldn't tell you". However, he did say he harmed himself by cutting his arms and wrists with razor blades. He has also used an iron to burn himself. On further questioning, Mr. X stated that he has only self harmed during psychotic episodes. He stated that the pain distracts him from hearing the voices and reiterated that voices do not compel him to harm himself.

Mr. X denied attempting to harm others in the past and denied homicidal ideation.

Past Medical History

- Mr. X was diagnosed with HIV three years ago. Apart from an initial period of "night-sweats" which prompted him to see a doctor and consequently become diagnosed Mr. X has been otherwise well, he has not been commenced on anti-retroviral medications and has been attending a Sexual Health Clinic since his diagnosis. He has not experienced any AIDS defining illnesses. Mr. X stated that his CD4 lymphocyte count is within the normal ranges and his HIV viral load is stable.

Drug & Alcohol History

Substance Use

Nicotine

Mr. X has a 20 pack year smoking history.

Alcohol

Mr. X denied alcohol consumption. He stated his father was an alcoholic and he did not want to be like him.

Cannabis

Mr. X confided that he began smoking cannabis at the age of 13 years, influenced by his siblings and friends who were users. He continued the use of cannabis following his diagnosis of schizophrenia because while he was smoking he "felt better". He was having approximately three cones a day.

Mr. X stated that he had discontinued the use of cannabis two weeks prior to his suicide attempt and he was highly motivated to "stay away from it".

Mr. X denied a past or current history of intravenous drug use.

Medications

Quetiapine 200mg b.d

Developmental, Family & Social History

Mr. X denied developmental delays during his childhood. He disclosed childhood sexual abuse committed by his Uncle from the age of 9 to 11 years. He has not confronted his Uncle about this or informed his family. Mr. X described his premorbid personality as being anxious and fearful. He denied a forensic history.

Mr. X is not close to his family. His parents and two younger sisters live in Adelaide. Mr. X disclosed that his mother is unhappy regarding his pharmacological treatment as she feels he needs spiritual healing and not medication to treat his symptoms. This disconnect from family, culture and spirituality is very significant for an Aboriginal person. Mr. X's main support is his partner.

On questioning in regards to *psychiatric conditions* in his family:

- Mother: untreated depression
- Sister: diagnosed with schizophrenia 5 years ago, 1 hospitalization since diagnosis, currently controlled well on medication, employed and functioning well with her husband and children
- "Most" siblings: abused cannabis and alcohol in the past and "some" continuing their use (Mr. X unclear regarding details)
- Uncle: committed suicide 20 years ago

Mental State Examination
Appearance
Mr. X is a slightly overweight Aboriginal man of average height. He appeared to be well-groomed with adequate hygiene.

Behaviour
Mr. X behaved appropriately. He was willing, co-operative and polite. He sat in a relatively fixed posture throughout the interview and made only limited movements.

Rapport
Mr. X was co-operative, well-mannered and polite throughout the interview.

Speech
Mr. X's speech was of normal and appropriate rate, volume and quantity.

Mood
Mr. X described his mood as being one of "calm". On further questioning, he stated that he currently was not depressed nor had an elevated mood.

Affect
Mr. X's affect was appropriate in terms of range and variation.

Thought
Stream:
Mr. X's stream of thought was normal. He displayed no flight of ideas, clanging, punning, inhibition or retardation of thinking or circumstantiality. In addition, there was no indication of perseveration or thought blocking.

Possession:
At the time of interview Mr. X denied any form of thought alienation such as thought insertion, withdrawal or broadcasting.

Form:
There was no evidence indicating disorders of conceptual or abstract thinking. Mr. X did not display derailment (loosening of associations) or incoherence (word salad). He did not demonstrate neologisms, tangentiality or word approximation.

Content:
At the time of interview there were no abnormalities of thought content including delusions, overvalued ideas, preoccupation with any themes, obsessions, compulsions or phobias. Mr. X did disclose feeling unsafe if he returned home as he felt he may attempt suicide again.

Perception
At the time of interview Mr. X denied experiencing auditory, visual, olfactory, tactile, gustatory or somatic hallucinations.

Cognition
Orientation:
Mr. X's orientation to time, place and person was intact.

Attention & Concentration:
Mr. X could only complete serial 7s to the number 86. He spelled "WORLD" backwards as "DRLOW". However, he seemed to be experiencing performance anxiety.

Memory:
Mr. X's immediate and short term memory was good. He remembered all four objects.

Visuospatial Ability:
Mr. X was asked to draw a clock-face with the time being 1 o'clock. Although the clock was drawn adequately with the numbers in the appropriate order, the short hand was pointing to the 12 and the long hand to the 1.

Abstract Thoughts:
He quickly determined that the similarities between an apple and a banana were that they were both fruit, food and contained seeds. Mr. X could not deduce what the proverb 'a bird in the hand is worth two in the bush' meant.

On the Mini Mental State Examination Mr. X achieved a score of 27 out of a possible 30

Mr. X's cognition was found to be adequate considering his cultural background and educational background of completing year 12.

Intelligence
An estimation of Mr. X's intelligence was made to be average. This estimation was deduced by assessing his recall, vocabulary used and level of functioning.

Judgment
Mr. X's judgment appeared to be good at the time of interview.

Insight
Mr. X freely admitted that he does have schizophrenia and requires help regarding his suicidal ideation.

Risk Assessment
Suicidality: High

Mr. X disclosed suicidal ideation, intent and plan. He also had the means.

Investigations
To be performed during hospital admission and on regular reviews:

- Full blood count
- Electrolytes and urea
- Liver function tests
- Thyroid function tests
- HIV monitoring: HIV viral load, CD4 count
- STI screening: first void urine for chlamydia and gonorrhea. Syphilis serology, Hepatitis A and B serology
- Urine drug screen

Diagnosis
DSM-IV Multiaxial Diagnosis

Axis I:*Mental Disorder*

- Paranoid schizophrenia
- Cannabis abuse
- 20 pack year history of cigarette smoking

Axis II:*Personality Traits/Disorder*

- Borderline personality traits
- Dependent personality traits
- Poor coping strategies for stress
- Withdrawn and submissive personality
- Difficulty trusting people

Axis III:*Medical Conditions*

- HIV positive

Axis IV:*Psychosocial & Environmental Stresses*

- Withholding his HIV status from his family
- Mr. X feels he is a "burden" on his supportive partner and feels guilty as Mr. Z is taking time off from work and considering retirement to care for him
- Unemployed for the past eight months

Axis V:*Level of Social & Occupational Functioning*

- Currently functioning well in long term intimate relationship, although he appears to be a submissive partner
- Unemployed, unable to maintain employment in the past
- Global Assessment of Functioning: 55 – Moderate to severe symptoms (e.g. flat affect, suicidal ideation), moderate to serious impairment in social, occupation, or school functioning (e.g. has one meaningful interpersonal relationship, unable to keep a job, history of poor interpersonal relationships, conflict with father)

Formulation& Summary

Mr. X is a 34 year old Aboriginal man in a supportive long term homosexual relationship and living with his partner. He was diagnosed with schizophrenia at the age of 19. His schizophrenia is not well controlled as he experiences frequent relapses and hospitalisations due to his chronic abuse of cannabis. Mr. X's schizophrenia has affected his life immensely, particularly the social and work aspects.

Mr. X has many predisposing, precipitating and perpetuating factors leading to his presentation. The main factors include a family history of schizophrenia, history of substance abuse, childhood abuse, poor coping strategies, extensive past psychiatric history, history of poor adherence to medication, unemployment, conflict with his father and limited contact with his family. Protective factors include motivation to cease cannabis use, recent adherence to medication and a supportive partner.

Management

Mr. X was assessed to be at high risk of suicide at presentation and was sent to hospital for admission and further management.

Short and long term management plan:

To minimise symptoms, improve quality of life and prevent future psychotic and self harm episodes

Non-pharmacological management

- Regular Psychiatrist and General Practitioner reviews
- Further psychoeducation to improve insight and understanding of his illness and need for medications
- Addressing cannabis and cigarette use. Motivational interviewing to cease these recreational drugs
- Psychotherapy to improve his coping strategies
- Support services: increased linkage with Aboriginal Medical Service, Aboriginal Drug & Alcohol workers
- Support services for his partner

Pharmacological management

- Mr. X will require an adjustment to his antipsychotic medication regime. An increase in his quetiapine dose would be warranted by slow titration
- Domiciliary home visit to identify and remove previously prescribed medications