Recommendation Form

Date: **March 5, 2021**

Case Synopsis:

Description of the client (e.g., demographics, education, employment, primary source of income, social support, etc.)

27 year old single female who lives at home with her parents. She is unemployed and is financially supported by her parents. She studied abroad, completing 3.5 years of post-secondary studies in social work though did not complete her degree. In addition to her parents she finds support from her sister and maternal grandmother.

Description of the suspected psychiatric diagnoses, substance use, and current presenting concerns. Also include relevant developmental, social, and family history.

Client has a history of generalized anxiety disorder, which was diagnosed at the age of 9. In the fall of 2020 she had an admission to hospital for a first psychotic episode with a broad differential, including bipolar 1 disorder, psychosis NOS, brief psychotic disorder, and possibly PTSD. At the time she presented with agitation, irritability, poor sleep, pressured speech, bizarre behaviors and thoughts, disorganized.

Client grew up in an environment where there was a lot of conflict between parents. Substance use was present in both parents during the client's childhood. She completed high school and studied graphic design in college. She later moved out of the country to study abroad, during which time parents noted that she was expressing grandiose delusions. While studying she had some employment in bartending and at a call center. Client has a history of being in abusive intimate relationships. There is also a history of sexual assault at the age of 19.

Her brother has a diagnosis of depression, alcohol and substance use, borderline and dependency traits.

Client is currently presenting as disorganized, impaired concentration and memory, possible Capgras delusions, labile, mood is incongruent to affect. Her movements are bizarre. For example, tongue gliding over teeth, unusual tongue movements, jaw locking, eyes rolling and staying fixed, neck contortion. According to her mother, these started when the client was tapered off paliperidone.

The team is concerned about ongoing challenges with providing care. The client continues to present with ongoing symptoms of psychosis and poor functioning. Recommendations made by the team to the family are often met with resistance or declined.

Supporting information, safety concerns, medical conditions, 6-point wellness check, etc.

Client has a history of aggression during her hospital admission.
She has a history of suicidal ideation.
She currently has difficulty engaging in self care, eg inappropriately dressed wearing winter clothing in the home, unkempt.

Past/present treatment interventions, as well as the client's current goals for treatment and strengths that will support them to work towards their treatment goals.

Client was discharged from hospital on Paliperidone 9 mg, which was subsequently reduced by parents to 6 mg and eventually discontinued due to concerns about client's movements and elevated prolactin. At one point the client was on no antipsychotic for 6 weeks. Parents have inquired about a number of medications including diazepam and clozapine.

She is currently on quetiapine 300mg, which parents are dispensing in 3 divided dose, and clonazepam 0.5 mg prn. It has taken a lot of encouragement to increase quetiapine to this dose. Client and family have been told that this is a sub-therapeutic dose of quetiapine for the treatment of psychosis. A trial of benztropine was declined by parents.

The client's psychiatrist is wanting to seek a second opinion and recommended that the family bring the client to hospital for assessment. This suggestion has been refused by family. A referral has also been made to CAMH for a medication review to clarify whether the movements are a presentation of psychosis or a medication side effect.

A medical work up is in progress. Client had a CT scan in September 2020 during her admission, which was unremarkable. This was followed by an MRI with findings of Cavernoma and Developmental Venous Anomaly, and it was also noted that this finding is not related to the client's psychosis. An enhanced MRI was suggested, which parents are holding off on due to potential risks of the scan. The client is waiting to see neurosurgery, and has a referral to neurology at Toronto Western Hospital Movement Disorders Clinic.

The client has expressed goals for being more independent.

The family has received extensive support and education from the EI team.

Reason for case consultation and any specific questions that the provider would like answered.

1) Suggestions and recommendations on how to manage family's reluctance to follow treatment plan and recommendations.

2) Recommendations on how to manage team burnout while continuing to provide care. Contact with family is frequent and extensive, the team fears being taped during appointments, splitting, reports of complaints.

3) Recommendations for assessments of programs for the client in order to get a second opinion about diagnosis

Summary of Recommendations:

Recommendation: description of recommendation.

Elaborating on recommendation, and clarifying information (e.g.; where to access scales, monitoring required when prescribing medication, etc.):

1) Consider exploring the family's resistance to treatment recommendations. Often family's behaviors come from a place of fear or guilt, and it might be helpful to explore whether these are driving some of the hesitation to accept recommendations.

2) Consider connecting parents with other family members. Other families may offer a "safer" space for the parents to share their concerns and to learn from other families with lived experience supporting a loved one with psychosis.

3) Clarify client's needs and goals, which often get lost when family members are playing a dominant role in their care.

4) Consider independent housing for client.

5) It may be helpful for the various roles in Navigate to hold joint appointments when seeing the client and family to address concerns about splitting.

6) Regular team debriefs can help to share the burden of care and address the burnout the team might be experiencing.

7) An assessment under the Mental Health Act (Form 1) and admission may be necessary given the risk of inability to care for oneself. We must also keep in mind that using the Mental Health Act can potentially alter the therapeutic rapport, particularly if the client remains unwell when discharged back to the outpatient team.

8) An admission would allow for assessment of treatment capacity, appointment of a capable substitute decision maker, assessments to further clarify diagnosis. Collaboration between inpatient and outpatient teams will be important to highlight family dynamics and address areas of care that have been challenging to manage as an outpatient.

9) Follow up with CAMH medication assessment clinic, neurology, and neurosurgery as these all are appropriate referrals.

Follow-up

If it would be helpful to have some further discussion and consultation regarding this case, please consider bringing it back to ECHO EPI-SET in the next month. To do so, please connect with: Brannon Senger (brannon.senger@camh.ca) and Andrea Alves (andrea.alves@camh.ca).