

David – 2317 Words

David* (not his real name) is a single 48 year old Greek man who lived all his life with his mother, and considered himself to be her carer. He has never been employed and lives in rental accommodation

Presentation

David presented via a forensic referral following a hospital admission where he was diagnosed with schizophrenia. This was his first psychiatric presentation, and all organic screens were negative.

The index offence was an assault on a middle aged woman at the supermarket, yelling profanities at her, believing she was filming him on her mobile telephone. He remained at the supermarket and when police arrived, he resisted arrest, pushing them away and struggling. He reported the thoughts had been present for at least two years but had never acted on them previously. He believed he was followed whenever he left the house and reported recent onset of command hallucinations telling him to kill his mother.

David spent two weeks in hospital, commenced on oral paliperidone 6mg nocte, and in this time his mother was admitted to a nursing home.

When I met David, 3 weeks following the incident, he was parkinsonian in appearance, with clear signs of akathisia. Other medication on hospital discharge was diazepam 2mg bd, for his anxiety around his arrest and the court case. He continued to believe he was being watched, followed, filmed and talked about, but said it no longer upset him and he would not act on it. Command hallucinations had resolved, and he could hear murmuring, but no clear words when he left his house. The risk appeared to have reduced from high, to low/moderate.

Social History

David's mother had mobility problems and diabetes, and he was responsible for all the household chores, shopping and cooking, and managing their finances. He assisted his mother with her ADL's without any outside supports. He was struggling with being alone, post discharge, his only 'friend' being his landlord. His landlord took him shopping each week (he does not drive) and invited him to dinner once per week.

David reported he had always been too shy to have relationships or friends, and he spent his time watching television.

Medical History and Psychiatric History

None of note, prior to this presentation.

Family History

David has an older sister living in a regional centre, with monthly phone calls the only contact with her. His mother has osteoarthritis and osteoporosis, type 2 diabetes, hypertension and elevated cholesterol.

Drug and alcohol history

Nil use of drugs or alcohol, a non smoker

Developmental History

David's parents migrated to Australia in the 1960's, and he and his sister – 7 years older - were born in Australia. They have no extended family here and did not belong to any religious or other groups. His mother never learned to speak English, which is why he managed all the paperwork at home, from an early age, and acted as an interpreter for his mother.

His father did not permit David to see friends outside school, nor did his parents have friends or social contacts, and when he was 12 his parents' marriage ended. His mother left due to the frequent arguments (no physical violence reported) and he and his sister remained with their father, his sister soon also leaving home. David decided to just do as his father said to avoid arguments, but at 16 there was a dispute with his father about his school grades, and he left to live with his mother. After this his father constantly harassed him and his mother, banging on the door and rattling the handle, often all night – until they moved house and his mother took out a restraining order. The family was not connected with the Greek community, and David did not have a Greek sense of identity.

He enrolled in Engineering at University but failed several subjects in first year and did not continue. He felt bored at home and was unable to find employment.

David told me he was embarrassed about not completing university and never having a job or relationship, and scared of being alone once his mother died. He described himself as shy and introverted, anxious and worried he may say the wrong thing, make a mistake or do something silly. He said he was also embarrassed about his family life, and believed that if he met any new person, he should tell them all these things about himself.

Mental State Examination

David was a thin anxious man who arrived 30 minutes prior to the appointment time. He appeared older than his years and sat clenching his hands in his lap, his legs restless. He cooperated with assessment and made good eye contact, but there was evidence of parkinsonian facies and gait, as well as mild akathisia. Conversation showed no disorder of the flow of thought, but he continued to hold paranoid delusions. Auditory hallucinations were present. Attention, memory and concentration appeared intact. Judgment was limited, as was his insight,

Impression

David had been experiencing a psychotic illness for at least two years, in the setting of lifelong problems in the area of personality. He was avoidant and isolative, avoiding interpersonal contact where possible, and unwilling to be involved with people. He had never had an intimate relationship due to fear of being negatively judged or ridiculed. He felt inadequate, avoided new activities and people, and had never married or moved out of home. There was a fear of embarrassing himself in public. This can be seen as stemming from an early life where there was conflict between his parents, he was scared of a domineering father who belittled and embarrassed him, and he was isolated from others

from an early age. He then lived an isolated life, his mother's key support and confidante, and did not cope at University.

In this setting he developed a psychotic illness, which due to his isolation went undiagnosed for two years, perhaps much longer. He assaulted a woman at the supermarket, shouting profanities and resisting arrest. This was very much out of character, as he always actively attempted to avoid being noticed.

Diagnosis

Schizophrenia – late onset
Avoidant personality disorder
Social Anxiety Disorder

Management

Due to side effects from paliperidone medication was changed. David was given information on the available options and side effects of each, and he chose to try olanzapine, aware of metabolic risks, hoping it would assist with his anxiety about court and about living alone. A cross over approach was utilised due to the risks associated with any exacerbation of symptoms, and this went smoothly. He transitioned to olanzapine 10mg nocte. His diazepam was weaned and ceased after the legal proceedings concluded.

Over the subsequent 10 months, I saw David regularly – initially weekly to monitor closely, gradually reducing to 6 weekly. There was no excess sedation or weight gain from olanzapine.

He engaged with a local GP, who saw him weekly initially, then fortnightly, monthly and eventually 6 weekly.

I wrote to the GP after every review and telephoned her every 3 months to discuss progress and plans. She monitored his metabolic screens every 6 months, and counselled him on lifestyle.

A case manager was appointed and met with David face to face every 2 weeks, often visiting his home to monitor how he was coping. His home was immaculate, and his diet good. Self care was always excellent. His case was discussed at clinical reviews with the team every 3 months when stable, more often when there were problems.

His sister was contacted, with David's consent but did not want to be involved.

We attempted to support David to engage with volunteer work or community activities, but he continued to resist this. He declined to engage with an NGO worker to support him.

David's mother gained a permanent place in the nursing home and he visited, by bus, fortnightly. He continued to be supported by his landlord as before.

Psychoeducation was attempted, with limited understanding of illness gained but a willingness to continue medication as it made him feel much better, and less worried when he left the home.

David's case came before the courts and I was requested to write a report. David agreed to me doing this, as opposed to seeing someone independent. He did not want to have to meet another new person and go over events again. He was found not guilty due to mental impairment and sentenced to 6 months of psychiatric treatment and supervision.

David's mental state and function remained stable throughout this time, with delusions still present but no longer bothering him when he left the house to go to the shops, catch the bus or go for a walk. He was quietly spoken, polite and cooperative, with good eye contact and good rapport.

In the month before David was due to come off the forensic supervision order, I met with him to discuss discharging his care to his GP. He was agreeable to this, and I telephoned his GP to discuss it with her. She was happy to continue with his management – the same medication, lifestyle discussions, and regular metabolic monitoring. Her contact had reduced to 6 weekly.

More recent events

The week before his supervision order ended (3 weeks ago) the team had a telephone call from his sister saying he was unwell and had assaulted someone again, once more arrested but not admitted to hospital. On review a few days later, he was irritable, confrontational and argumentative. David reported that he ceased his olanzapine a week prior to the new assault, providing no reason for this. He recommenced it two days before seeing me. His paranoid delusions had become more intense after he ceased medication, but command hallucinations were denied.

My management was

- Advise the forensic team of these events
- Advise his GP of these events (via a telephone call)
- Commence oral aripiprazole, with a plan, if tolerated to commence depot aripiprazole (this was chosen due to his side effects from oral paliperidone)
- Weekly psychiatric review
- Have a low threshold to readmit to hospital
- He became a 'client of concern' for the team, with daily team communication and daily team follow up after the assault
- Apply for a community treatment order if non-compliant with depot medication

David's mental state has settled quickly, and he is no longer irritable and argumentative. The intensity of his delusions is settling, with no further plans to act on these. He is seeing his GP weekly again, and there are plans for him to receive his depot at the GP practice. Currently my team is monitoring for side effects, and if necessary, we will commence benztropine and/or reduce the dose.

My formulation around this relapse is that it occurred in the setting of supports from the forensic (corrections) service and the mental health service, as well as his GP, gradually being withdrawn with the improvement in his mental state. Although these were not 'intimate' or close relationships, for him they were likely to be very important, and he faced being left mostly at home, without his mother there, and just the weekly contact with his landlord, his GP every 6 – 12 weeks, and nothing else in his life. The scaffold that had been present for almost 12 months was being withdrawn – though I doubt he was consciously aware of this motivation. A more superficial explanation is that with the withdrawal of mental health and corrections services he believed he no longer needed treatment – though

this had been addressed with him at each interaction I had, the need to remain on it long term to manage his concerns about leaving the house.

The service philosophy is for episodic care, and he cannot remain with a psychiatrist and case manager in the service long term if his mental state is stable. We will attempt again to link him with community supports, likely to have him with the service for another 12 months once these offences go to court again. Plans to transfer care to his GP are on hold currently.

CBD Domains

Assessment

A thorough assessment was done, as indicated. This included a dynamic formulation and a forensic formulation. The case was reformulated in the period just prior to this submission.

Treatment

Treatment included medication, psychoeducation, and attempted psychosocial interventions. Medication was changed due to side effects, with close monitoring for exacerbation during this time, due to risk concerns. He has recently been commenced on depot medication due to non-compliance in the period immediately prior to planned discharge from the service. Metabolic syndrome has been discussed and is being monitored, with advice on diet and lifestyle. David continues to have little insight into the fact that his beliefs are the result of illness and are not true.

Collaboration

As indicated, there was close collaboration within the multidisciplinary team, and with his GP. There has also been ongoing collaboration with the forensic service. His sister, and landlord, have not wanted to have contact with the service, but it has been offered and both know how and who to contact if they have concerns.

Communication

There has been regular communication throughout – with the GP in writing and via telephone, and with the forensic service. The Community Mental Health team has monthly face to face meetings with the Forensic Mental Health Team to discuss joint patients.

Professionalism

Evidence for this includes the discussion with David about the initial reports for the court and considering the ethics and problems of being both his treating doctor and the person writing these reports. He was told what the likely content of the reports would be, and this did not negatively impact the therapeutic relationship.

I discussed his case in my peer review group, as I found the relapse in the context of planned discharge interesting, reflecting his likely unconscious desire to continue contact with services, rather than confront his fear of 'being alone'.