Week 4: Substance-Related and Addictive Disorders

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NRNP 6675: PMHNP Care Across the Lifespan II

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NRNP/PRAC 6665 & 6675 Comprehensive Focused SOAP Psychiatric Evaluation Template

Grand Rounds Discussion: Complex Case Study Presentation

This is an assessment on Mr. DG he is a 33 year old African American post discharge from hospital with exacerbation from schizophrenia and preoccupied with delusions and paranoia religiously preoccupied. Possibly triggered by his use of marijuana and mushrooms. Each time he use these substances he has a psychotic episode , otherwise he is doing well with his medication and is believed to be compliant.

Objectives: To target his symptoms with treatment schizophrenia with psychosis.

Prevent relapse and increases adaptive functioning so that the patient can be integrated back into the community.

To effectively manage signs and symptoms of schizophrenia with psychosis at the lowest possible dose.

Reduce the impact of schizophrenia on the quality of his life, social functioning, and longevity.

Eliminate the use of marijuana and mushrooms which causes his relapse.

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Subjective:

CC (chief complaint): MR. DG is a 33 year old African American post discharge from hospital with exacerbation from schizophrenia and preoccupied with delusions and paranoia religiously preoccupied. Possibly triggered by his use of marijuana and mushrooms.

HPI: Mr. DG is a 33 year old African American who presents for an initial evaluation post hospital discharge for treatment for exacerbation from schizophrenia with delusions and paranoia religiously preoccupied. He was diagnosed with schizophrenia in early 20's, this client is a poor historian. His brother and sister has schizophrenia and one of his parents.

He had a normal upbringing with no history of trauma or abuse. He was doing ok for several months with his last visit being in January, 2022 until June, 2022 for a follow up after hospitalization. Upon arrival at first follow up he was isolated and quit very hard to communicate with. Later on his follow up visits was with his girl friend present he was still disheveled and was reported to being very paranoid and delusional waking up during the night telling her that she must get out of the bed onto her knees and pray to wash away her sins and cleans her soul for the things that she has done. He would make her tell him she loved him and question her about cheating on him and go through her phone in the middle of the night.

He was started on Haldol and marked improvement was noted a week later. His appearance was more clean he cut his hair he was smiling and more communicative and had stopped the waking up during the night with request to pray and questioning if she were cheating. He looked like a different person. At week three follow up he is doing well with some slight tremors the aims test was conducted. And no changes in medications were done we talked about possible using cogentin if there was any worsening of side effects. His sleep is fair and he has to use his Ativan at times to help him sleep. Client is also taking melatonin and will consider something later to help him sleep after being on the his Haldol for some time. May consider Vistril or doxapin at a later time. He has been taking Haldol 3mg po twice daily with great results. His girlfriend had noticed that during the evening he was doing very well with no psychotic behavior and was thinking that maybe he could reduce it more or stop taking it eventually. They were both educated on how this was a progressive disease and it will not cure the schizophrenia but only treat the symptoms and keep him stable. There was also concerns of taking this medication long term and it was explained to them that although there are some negative effects of taking this medication long term there is also a worse outcome longterm of not being compliant and taking medication with increased exacerbation and loss of mental capacity for him if not being treated will be much worse outcome. Also the side effects of these medications are very manageable. This client is also a graduate student and is now able to function and participate in his program again.

Family Psychiatric History: Brother and sister and one of his parents has schizophrenia. No history of suicide.

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Substance Current Use: Marijuana and mushrooms

Medical History: Denies

Psychiatric History: Admitted inpatient 5 times.

- **Current Medications**: Haldol 3mg bid for Schizophrenia. Ativan 0.5 once a day as needed for tremors or insomnia.
- **Trial medications:** Geodon others unknown
- **Psychotherapy:** Denies
- **Allergies**: NKDA, NKFA
- **Reproductive Hx**: No children, no sexual concerns

ROS:

- **GENERAL:** Good well groomed, No weight loss, fever, chills, weakness, or fatigue.
- **HEENT:** No visual loss, blurred vision, double vision, or yellow sclerae. Ears, Nose, **Throat:** No hearing loss, sneezing, congestion, runny nose, or sore throat.
- **Speech:** +normal, + coherent: +goal directed.
- **Thought Process/ Abstract Reasoning:** + Organized: -Disorganized: - Hallucinations: -Delusions.
- **Associations:** +normal.
- **SKIN**: No rash or itching.
- **CARDIOVASCULAR:** No chest pain, chest pressure, or chest discomfort. No palpitations or edema.
- **RESPIRATORY:** No shortness of breath, cough, or sputum.
- **GASTROINTESTINAL:** No anorexia, nausea, vomiting, or diarrhea. No abdominal pain or blood.
- **GENITOURINARY:** Denies burning on urination, urgency, hesitancy, odor, odd color
- **NEUROLOGICAL:** No headache, dizziness, syncope, paralysis, ataxia, numbness, or tingling in the extremities. No change in bowel or bladder control.
- **MUSCULOSKELETAL:** No muscle, back pain, joint pain, or stiffness.
- **HEMATOLOGIC:** No anemia, bleeding, or bruising.
- **LYMPHATICS:** No enlarged nodes. No history of splenectomy.
- **ENDOCRINOLOGIC:** No reports of sweating, cold, or heat intolerance. No polyuria or polydipsia.
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Objective:

Physical exam completed by PCP.

Diagnostic results:

Aims Test, CBC, CMP, Lipid panel, B12 and A1C. BMI due to possible weight gain and metabolic syndrome. LFT's for base line as medication can be damaging to the liver.

Assessment:

Mental Status Examination:

Oriented to time, place and person.

Mood: euthermic

Memory is intact for recent and remote events.

Attends to task normally.

Attention: attends to tasks normally.

Speech/Language: + expressive and receptive communicate skills normal.

Fund of knowledge: +demonstrates good fund of knowledge.

Diagnostic Impression:

Opioid Use Disorder with severe psychosis : The DSM-V Criteria for Substance Use Disorders: A: One or more abuse criteria within a 12-month period and no dependence diagnosis; applicable to all substances except nicotine, for which DSM-IV abuse criteria were not given. B: Three or more dependence criteria within a 12-month period. C: Two or more substance use disorder criteria within a 12-month period. And D: Cannabis withdrawal has been added in DSM-5. This clients use of marijuana and mushrooms has contributed to his psychosis. Craving or a strong desire or urge to use the substance has also been added (Hasin et al., 2013).

Bipolar Disorder 1: DSM-5, is a classic manic depressive disorder, with the exception that neither a depressive episode nor psychosis has to be present for diagnosis (Severus & Bauer, 2013). Manic episodes that last at least 7 days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, depressive episodes occur as well, typically lasting at least 2 weeks.

Schitzo Affective disorder unspecified: DSM-V criteria is: A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

1 delusions

2 hallucinations

3 disorganized speech (e.g., frequent derailment or incoherence)

4 grossly disorganized or catatonic behavior

5 negative symptoms (i.e., affective flattening, alogia, or avolition)

B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement). This client was experiencing all of these symptoms and it has severely effected his life and ability to participate in his graduate program (Substance Abuse and Mental Health Services Administration , 2016).

MDD severe with psychosis: The DSM-V states that an individual must have five of the above-mentioned symptoms, of which one must be a depressed mood or anhedonia causing social or occupational impairment, to be diagnosed with MDD. History of a manic or hypomanic episode must be ruled out to make a diagnosis of MDD. Per DSM-5, other types of depression falling under the category of depressive disorders are:

- Persistent depressive disorder, formerly known as dysthymia
- Disruptive mood dysregulation disorder
- Premenstrual dysphoric disorder

- Substance/medication-induced depressive disorder
- Depressive disorder due to another medical condition
- Unspecified depressive disorder

(Bains , Abdijadid , 2022)

Reflections:

Patients with OUD have been shown to have a higher risk of developing schizophrenia. Patients with both schizophrenia and OUD are less likely to receive standard of care including medication-assisted treatment (MAT) for opiate use disorder and have worse outcomes compared with patients with schizophrenia who do not abuse opioids. OUD significantly increases the risk of converting patients from prodromal schizophrenia states to schizophrenia or schizoaffective disorder. Second-generation antipsychotics, long-acting injectables, and MAT for OUD should be utilized in a dual-diagnosis and treatment approach for patients with schizophrenia and OUD. (LE;, 2020).

This client is young and has a very good support systemic his girlfriend who is also a therapist. He has been a client here for some time and has been stable until he uses marijuana and mushrooms and he has a psychotic and delusional exacerbation and end up back In to the hospital inpatient setting. He is able to manage his grad school work as well. Every episode he has will cause further loss of his mental capacity.

3 possible discussion questions

How can we effective increase compliance in his medication treatment plan?

What can be done to encourage him to not use marijuana and mushrooms?

Do you think that Subutex (Buprenorphine) or Suboxone (Buprenorphin/naloxone) or naltrexone alone might be an option to assist him in not using marijuana and mushrooms as the gold standard treatment for OUD?

Case Formulation and Treatment Plan:

The treatment course will be to continue with the haldol 3mg BID and after 4 weeks of compliance and no further or worsening side effects to add on the Haldol Decanate injection at 50 mg and continue the oral Haldol for 14 more days as he adjust to the change and titrate as needed to maintain his good mood. He will take Ativan as needed for his hand tremors and at night to help him sleep. Follow up in 2 weeks for a medication management appointment to re-evaluate his self-reported symptoms and ensure the medication at this dosage is still effective at controlling those symptoms. The patient was instructed to call, and schedule sooner if current symptoms worsen or new behaviors are noted.

The oral route is relatively slow, reaching peak plasma concentration in 1.7 to 6.1 hours, compared to 15 minutes in intranasal and intravenous routes and 37.5 minutes in intramuscular. Parenteral routes are preferred in acute schizophrenia. Intramuscular haloperidol decanoate provides slow and prolonged release when administered as a depot intramuscular injection, which helps eliminate the problems of non-compliance (Hanafi et al., 2017).

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