Schizophrenia management and treatment plan

Practice Scenario:

Millie is a Caucasian female who is in her late fifties. This client has a long history of psychiatric issues. She recently was discharged from a state psychiatric hospital after a mandated inpatient stay. The client has a diagnosis of paranoid schizophrenia and experiences paranoid delusions. The client has exhausted many resources that have been available to her and is need of a long-term placement once she is discharged from the hospital. At this point in time Millie has been stabilized on medication due to her stay at the psychiatric hospital.

My role in Millie’s treatment is clinical case manager for a group home that she is applying to. Millie and I have been working together since about a week prior to her discharge from the hospital. I am working with Millie in order explore her goals for treatment in our program, ensure that she is able to transition back into the community, and provide support and advocacy for Millie and her family. As part of the program, the staff would be responsible for administering her medication, assisting her in securing a job, as well as teach her life skills that will help Millie succeed in the group home setting.

At this point in her story Millie has been stabilized on medication and is relatively stable compared to past presenting states. Although she is stabilized on medication, Millie continues to have delusional and paranoid thinking. Millie has limited insight into her illness and does not see herself as experiencing a serious mental illness. This has presented issues for Millie in the past as she does not recognize any issues and her motivation to change

is nearly nonexistent. This results in Millie frequently being noncompliant with medications.

The problem:

Millie experiences many psychotic symptoms as a result of her diagnosis of schizophrenia. These psychotic symptoms are well managed on medication but Millie has a history of nonadherence to her medication regiment in part because she has limited insight into her illness. Her nonadherence to medications causes distress for the client and her family as the client has a well-established pattern of entering the psychiatric hospital, becoming stabilized on medications, getting discharged from the hospital, managing for a short period of time before ceasing her medications, then the client decompensates and is placed in the psychiatric hospital again. Millie and her family are lacking a holistic approach to her treatment and are being given one solution for her psychiatric issues: medication. Medication is necessary in Millie's case as part of her treatment, but in order to successfully rehabilitate Millie a more holistic approach needs to be taken with her care. My role as the clinical case manager will be to explore with Millie her goals, connect her with other psychiatric supports such as a therapist, as well as to provide support and advocacy for Millie and her family.

Millie's Symptoms:

After her initial release from the psychiatric hospital Millie seems to be stabilized on medication. Her main symptoms present are her lack of insight into her illness and denial that she has a mental illness. In addition, Millie has had suicide attempts in the past that are directly related to her paranoid

delusions. When her psychotic symptoms are active, Millie also becomes withdrawn and isolated. She becomes paranoid and agitated when her daughter tries to engage in conversation with her. When Millie is experiencing psychotic symptoms, she becomes verbally aggressive and angered by her perceived intrusion of her affairs by her daughter.

Perspective of family members:

Sisters Susan and Tina check in regularly on Millie and sometimes they cannot get into contact with her. If this is the case they begin checking hospitals and local agencies to attempt to locate their mother. Due to confidentiality, the sisters cannot be given information regarding their mother's health and mental status. This constant cycle leads to feelings of anger and frustration that are experienced by the supporting family members. Family members are also frustrated by Millie's lack of insight into her own illness and symptoms. Millie's daughters share that Millie has a very limited support network of a few family members. Millie has been unstable for the past two decades, experiencing seventeen inpatient stays in psychiatric hospitals, had 8 different apartments, lived in three different boarding houses, and lived in a number of different motels. The sisters seem temporarily relieved when Millie is released from the hospital as Millie has been stabilized on medications and her symptoms have greatly reduced. However, the family members are familiar with Millie's patterns of nonadherence and know it is unlikely that she will continue on a medication regimen.

There is a point in the film where Susan interviews her father about Millie and her history of mental illness. She asks her father when he first noticed that there was something abnormal that was happening with Millie. Her father replied that he first knew that there was something that was seriously concerning about Millie's mental health was a few days after she returned home after giving birth to their first daughter. Millie had attempted suicide by cutting her wrists.

In addition, a cousin recalls a conversation that she had with Millie in which she asked Millie when she noticed that something was not right with her. Millie replied that she has never felt right. This same cousin recalled an instance in which Mille told her that Johnny Carson spoke to her though the television and told Millie that she should run for president. Tina, Millie's youngest daughter recalls being told that there were cameras in their house when she was growing up and being told that the CIA and the FBI were watching their family. Millie also conveyed to her children that teachers were spies and that they were out to get the family and could not be trusted.

Millie continued to be the primary care taker for her children until their adolescence, with her psychotic symptoms worsening. Millie eventually saw a psychiatrist who diagnosed her with schizophrenia. Even after her diagnosis Millie continued to worsen, becoming more withdrawn and psychotic. She sold her house and lost all of her monetary resources. Around this time in Millie's life she attempted suicide again. It is not until this later suicide attempt, after experiencing psychotic symptoms for many years, did Millie come into contact with the public health system.

Millie's strengths:

Despite her diagnosis and lack of long term rehabilitation, Millie has many strengths that will help her maintain recovery. Millie is intelligent and determined two strengths that when channeled correctly, will contribute to her long-term recovery. Millie is also quite likeable when her psychotic symptoms are managed through medication. At many points in the film Millie and her daughter are seen having pleasant outings together and Millie engages with her daughter by making jokes and observations. This likability will help Millie in creating stronger social supports as well as contribute to creating trusting and pleasant relationships with her providers.

Resources available to Millie:

There are a number of resources that are discussed in the film that are available to Millie. Millie received treatment through the psychiatric hospital in order to stabilize her. Additionally, Millie and her eldest daughter also discuss a transitional housing program that may be appropriate for Millie. Millie also received services through a nursing home facility and finally at a comprehensive group home where Millie received many supportive services.

Millie's perspective:

Millie has an extremely limited understanding of her illness. Early in the film, Millie states " There's something wrong with me I've been looking at it over and over when I was at the hospital. I'm here and I'm at the hospital because I lost all my money. And then I didn't even replace it. I know that's why I'm there.... Whether I fit into that category that mentally ill people fit into or not,

I’m bankrupt and there’s something wrong with me.” At one point in the film, one of Millie’s daughters asks Millie what she knows about paranoid schizophrenia. Millie responds that she knows what paranoid means but have never understood schizophrenia. It is clear throughout the presentation of the case in the film that Millie has a desire to be close to her children, but that she is unable to have a meaningful and rich relationship with her children due to her symptomology. She expresses feeling unattached to other people, almost as if she were an orphan.

Interventions:

Schizophrenia is a serious mental illness that is rooted in the biological distortion of certain aspects and functions of the brain (Coursey, 1989). Medication is a primary component of the treatment of schizophrenia with many individuals that are able to maintain successful rehabilitation once they have acquired the correct medication regimen (Coursey, 1989). Medication alone, however, should not be considered the gold standard of intervention for individuals with schizophrenia (Kane, 2007). Like Millie, many individuals with schizophrenia have nonadherence issues with medications. The factors that influence nonadherence fluctuate from client to client, however, the issue of nonadherence continues to be a persistent problem for many individuals experiencing schizophrenia (Kane, 2007).

The role of antipsychotics in preventing a relapse in recovery from schizophrenia is well established in the literature. The consequences for nonconcordance of medication also can be quite severe; hospitalization, relapse, emergencies, and dropping out of other aspects of treatment are all

possible consequences of the discontinuation of medication (Corrigan, 2016). Across various populations and diagnosis of serious mental illness there are four main, consistent factors that influence nonconcordance in clients; co-occurring substance abuse, medication side effects, the quality of the relationship between the patient and the prescriber, and practical problems that interfere with taking medication regularly (Corrigan, 2016). In Millie's case, it is likely that all of these factors, aside from substance abuse, played a role in her pattern of medication nonconcordance.

Many individuals with serious mental illness experience severe side effects from the medications they are prescribed. From the film, we can determine that at many points in her life Millie was prescribed individually or in combination, a variety of antipsychotics, antidepressants, and/or antianxiety medications. These medications can have stark and uncomfortable side effects such as persistent dry mouth, weight gain, seizures, fatigue, muscle dystonia, hair loss, among others (Corrigan, 2016). For medication nonconcordance that is a result of medication side effects, psychoeducation is a key intervention in the adherence of medication (Corrigan, 2016). Many clients feel conflicted and uncertain in taking medications due to the possible side effects (Deegan, 2007). Assisting clients in understanding why they are prescribed a certain medication and being open to hearing client concerns and feedback about medication and side effects is a key component of medication adherence (Corrigan, 2016).

Furthermore, the relationship between the prescriber is a fundamental component in medication concordance. A poor relationship between the client and their prescriber is often the most common factor in medication

nonadherence (Corrigan, 2016). Finding a medication regimen that is effective is a highly individualized process that requires a collaborative relationship that occurs over many meetings (Corrigan, 2016). A trusting relationship between the client and the prescriber is the space in which clients can freely discuss their concerns and resistance can be explored (Corrigan, 2016). Both prescriber and client should be aware that adherence to a medication regimen is difficult for any client regardless of their mental state or the origin of their illness (Kane, 2007). In Millie's case, we saw little interaction between Millie and her prescribers. We know from the film that Mille had a number of prescribers who all had a different idea of what medication regimen she should be on. There seemed to be little collaboration between Millie and her prescribers and this lack of collaboration and establishment of a trusting relationship could have played a role in Millie's medication nonconcordance.

Lastly, clients often face practical problems that result in medication nonconcordance. These practical problems can include lack of familial support, financial and insurance barriers, poor access to prescribers, forgetting, and others (Corrigan, 2016). A great example of this is illustrated in the film when Millie goes to the pharmacy to refill some of her prescriptions. She is nonchalantly read which medications she cannot refill and at what time she can refill them. For someone who is in a delicate mental state, this could be a detrimental experience towards medication nonconcordance. Millie may have just taken what medications she could get that day and not return to fill the others, she could have felt embarrassed in not knowing which medications she could and could not refill and then

decide to not return to the pharmacy, among other scenarios. Many times, individuals with serious mental illness partake in complex decision making in order to balance the costs and benefits of taking medication (Deegan, 20017). By engaging in shared decision-making clinicians can help support clients in navigating the complex world of medications.

Medication concordance is a key aspect of managing Millie’s psychotic symptoms. Given the importance of medication concordance for individuals with psychotic symptomology, there are many interventions that have been developed in order to maintain medication concordance. Many of these interventions include increased education of patients and support cognitive and behavioral changes (Corrigan, 2016). The most effective interventions for medication concordance are those that focus on practical problem solving, education, and motivation (Corrigan, 2016). These focuses of treatment when presented in a cognitive-behavioral approach with the addition of behavioral training, are quite successful in increasing rates of medication adherence (Corrigan, 2016).

Cognitive behavioral therapy (CBT), is a treatment modality that, when preformed in conjunction with medication, is effective for patients with schizophrenia in improving treatment adherence and symptom management (Turkington et. al, 2004). The key clinical components of CBT include building a trusting relationship with the provider, psychoeducation, normalizing, development of coping skills, and reality testing (Turkington et. al, 2004). These components all work in assisting clients to manage their psychotic symptoms. In addition, antipsychotics are quite effective at reducing positive symptoms of schizophrenia but are less effective at managing the negative

symptoms associated with schizophrenia (Kane, 2007). Incorporating a treatment modality that has a cognitive behavioral foundation, such as CBT, can teach clients how to manage symptoms that are not effectively targeted by medications.

For Millie, cognitive behavioral therapy would assist her in building a trusting relationship with a provider where she can express her concerns and be validated in her experiences. Throughout Millie's experience with the public health system and with other agencies, it seems that she is not viewed at a collaborator in her treatment as well as not validated in her experiences as someone living with schizophrenia. With the help of CBT, some of Millie's paranoid beliefs could be explored via reality testing and this may benefit her medication adherence. Furthermore, a CBT therapist can work with Millie to provide psychoeducation on schizophrenia and antipsychotic medications, this may provide Millie with some insight into her mental illness and to the experiences that she has had. Lastly, Millie expressed having experienced side effects of medications and still experiencing negative symptoms associated with her schizophrenia. A CBT clinician would be able to help Millie develop and implement coping skills that could help alleviate some of her negative symptoms as well as develop a plan to expresses her concerns regarding side effects to her prescriber.

Motivational interviewing is a second intervention that could be effective for Millie in establishing motivation for recovery and therefore supporting medication adherence. When used in populations with schizophrenia spectrum disorders, motivational interviewing increased task specific motivation in clients as well as increased treatment adherence and

attendance (Fiszdon et. al, 2016). When adapted for individuals who experience psychosis, motivational interviewing can be a key intervention in order to increase motivation for treatment and to ensure that clients attend treatment (Fiszdon et. al, 2016). Adaptions to motivational interviewing that can make this modality more appropriate for those who experience psychosis and/or negative symptoms are utilizing simple and concise questions and answers, providing an increased level of structure during the interview, being conscious and sensitive regarding emotional material, providing information in multiple modalities, slower paced interviews, and allowing clients time to process information presented (Fiszdon et. al, 2016). Motivational interviewing has the potential to create positive outcomes for client's experiencing schizophrenia and their families (Makuuchi et. al, 2016).

With adaptations in place, motivational interviewing could be a key component in motivating Millie towards treatment and medication adherence. From the onset of her illness, Millie is often in the precontemplation stage of change (DiClemente, 2008). She does not view herself has having an illness or a problem which has a direct effect on her motivation to change (DiClemente, 2008). Millie does not have motivation to change as she does not see herself as having a problem. By implementing motivational interviewing techniques from the onset of Millie's treatment, the literature would support a hypothesized increase in treatment attendance and adherence (Fiszdon et. al, 2016).

Many of the skills used in cognitive behavioral therapy and motivational interviewing overlap and therefore the two modalities are useful to use in conjunction (Mueser et. al, 2013). Since they so easily transition together it is

likely that motivational interviewing will be used in the earlier stages of treatment and then cognitive behavioral therapy is introduced at later stages of treatment (Mueser et. al, 2013). This combination timeline of treatment interventions allows for the clinician to increase buy in and increase motivation in the earlier stages of treatment and then move towards developing specific skills and strategies via CBT (Mueser et. al, 2013).

Treatment Plan:

Assessment is a key component of treatment planning. Assessment allows the practitioner and client to identify treatment and rehabilitations needs, provides a space in which to assess the strengths and weaknesses of an individual and their broader support network, informs the creation of a rehabilitation or treatment plan, and creates structure for the monitoring of progress and adaptation of the treatment plan (Corrigan, 2016). In addition, there are key values of assessment and treatment planning that include collaboration, shared decision making, and consumer centered goals (Corrigan, 2016).

The assessment method that I would first use for Millie is a semi-structured interview. This type of interview will allow me to hear Millie’s concerns as well as to assess her strengths and begin to formulate how we can collaborate together for her treatment (Corrigan, 2016). In addition to an interview with Millie, I would also conduct an informant based interview with her daughters. They are Millie’s legal guardians and can provide me with important information about Millie that will inform our treatment planning process.

After the assessment is completed Millie and I would work together to create her specific treatment plan. This plan would focus on the identified problem of medication nonadherence. Below is an outline of goals, objectives and specific interventions that will allow Millie to work towards recovery.

Goal : Better manage psychiatric symptoms.

Objective : Client will report implementing a new coping skill once a session.

Intervention : CBT to develop skills and strategies for dealing with psychiatric symptoms, stress, and conflict.

Objective : Client will report medication concerns or side effects to the case manager and prescriber.

Intervention : CBT to develop strategies that facilitate a trusting and open relationship with the prescriber, psychoeducation to increase knowledge of medications and their function.

Objective : Client will update case manager on medication concordance once a session.

Intervention : CBT to develop strategies that increase medication adherence, motivational interviewing to increased task specific motivation and to create motivation to work towards recovery.

Goal : Increase long-term treatment adherence.

Objective : Client will attend a CBT group to develop coping skills and strategies that will support long term recovery.

Intervention : CBT to develop strategies for change and recovery, psychoeducation on coping skills and effective use, social and concrete skill building to support long term recovery.

Objective : Client will gain understanding and insight of diagnosis of schizophrenia.

Intervention : Motivational interviewing to increase motivation to change and adhere to treatment, psychoeducation to gain insight into illness and recovery.

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