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Interprofessional Practice and Handling the First Break: A Case Study

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Eastern State Hospital (ESH) is a 239-bed acute psychiatric facility. This facility offers inpatient psychiatric treatment to adults eighteen or older in the least restrictive environment deemed appropriate for care. As with many interprofessional teams, social workers are on staff to assist in the psychosocial aspects of a patient's care (housing, income, employment, social support). The role of the social worker at ESH begins at admission and is ongoing throughout the course of the patient's stay. Patients are interviewed by the social worker to obtain necessary information to aid in the diagnosis, length of stay, and discharge of the patient. While the doctors and nurses are looking after the medical needs of the patient, social workers put more focus on the aspects of a patient's life that could have led to their admission and barriers that are apparent for the patient after treatment is complete.

Within the scope of the care provided by ESH, there are many different diagnoses that make themselves known. Oftentimes, a patient can exhibit certain symptoms, but as a treatment team we lack the adequate information needed to fully establish a diagnosis. In these cases, the patient is labeled with psychosis NOS, defined as disruptions to a person's thoughts and perceptions that make it difficult for them to recognize what is real and what isn't (NAMI, 2022) without additional symptoms exhibited to attach a specific diagnosis. For the purpose of the capstone assignment, a focus will be put onto one patient currently in the care of ESH.

Background information

Patient A is a 20 year-old single, African American woman who was admitted to ESH on 11/03/22 on a 72 hour court order from Franklin County. This is her first ESH admission. It is reported that the patient was brought to Frankfort Regional Medical Center by her family due to having a "mental breakdown." During this admission, the patient was evaluated by The Ridge (a community mental health center) and sent home with a prescription of Vistaril. It is noted by the

family that the patient began to exhibit worsening behavior in the days following her medical discharge. Per collateral information, the patient went days without eating or drinking and was found in her bathroom attempting to ingest her own feces with the hope of harming herself. The patient was taken back to Frankfort Regional Medical Center for further evaluation and testing, where she was petitioned by the courts to be admitted to ESH.

The patient is reported to have a history of anxiety and depression, beginning during the Spring of 2022 when she withdrew from all of her college classes and had to be brought home. According to collateral from her mother, there have been four recent deaths in the family, three of which in the last year and the behaviors she is exhibiting currently are a departure from baseline (the stability level of mental wellness). During the admissions process at ESH, the patient was interviewed by the admitting providers. Throughout this interview she is reported to have been making statements such as, “I need pain”, “I need to indulge”, and “technically yes” when asked about her suicide ideation, stating that multiple voices inside of her head were telling her these things. The provider notes that the patient seemed to be responding to internal stimuli as well and endorsing seeing “dark shadowy figures”, indicating the prevalence of visual hallucinations. Throughout the patient’s initial intake, she is described as being paranoid (looking over her shoulder constantly) and becoming extremely upset when specific exams were attempted to be administered (skin exam/abdominal exam). The patient exhibited repetitive mannerisms, frequently hitting her ankles against one another and holding her hands up in front of her in an almost choreoathetotic manner. These movements appear exacerbated by anxiety or distress. The patient was noted to be aware of these movements and initially says that they are voluntary but then says that they are involuntary. Once transported to the unit the patient will be staying on, she seemed to go into what is indicated as a catatonic state. More testing is needed to confirm this assumption.

When looking into the initial psychosocial aspects of the patient, it was found that there is a history of sexual abuse reported to the providers. When asked about this, the patient became guarded and responded with “a while ago, by a friend of a cousin, repeatedly.” The patient is reported to have stable housing as she currently resides with her mother but has no income. There is no indication of current or past legal issues. The patient has very limited outpatient services utilized. It was found that the patient has adequate social support to include family and friends. Strengths of the patient include communication of needs, stable housing, clear insight of condition and social support. Length of stay for the patient was indicated to be 5-10 days given progression of treatment and regression of her symptom burden.

Assessment

Of the focus points within this patient’s case, it was indicated that the presenting problems are as follows, lack of outpatient services, current symptom burden, and trauma history. From a prioritized standpoint, the patient’s symptom burden will be addressed first. Next, the allocation of outpatient services and finally trauma history. Given that ESH is an acute care facility, the level of attention on the patient’s trauma history will be lowered, but not fully cut out. The utilization of outpatient services will be more equipped to handle this aspect of the patient’s background, in this case, the patient will be referred to a community mental health center (CMHC) in her area upon discharge.

Working with individuals with a mental illness requires a look into the strengths and areas of improvement revolving around the patient. In this case, the patient has a major support system. This strength will be critical in the continuation of services, as well as continued stabilization once discharged from the facility. The patient’s insight to her condition and ability to communicate her needs will be a vital asset throughout the course of treatment. When patients are more “in tune” with their specific diagnosis, the adherence to the treatment plan increases,

approaches and strategies are more effective, and the patient's basis of thought is more linear. Services to be included within the treatment of Patient A are medication management, symptom burden regression, referral to outpatient services (CMHC), and psychosocial issue alleviation.

Plan

When a patient presents to the hospital, the process that they undergo is very similar to many patients. All tasks are completed within specific timeframes and by certain members of the treatment team (Appendix A). First, they are evaluated by the admissions staff to obtain primary knowledge of reasoning for admission. Then, a psychosocial assessment is completed to find more information about a multitude of aspects within the patient's life (substance use, legal history, guardianship confirmation, etc). Next, collateral calls are made to the patient's friends and family to gain more clarity on the reason for admission and any information that may be unclear. Following this, the patient is met by the providers to discuss their psychiatric needs and to begin thinking of approaches to take being that each patient is different. While this is happening, an initial personal recovery plan (PRP) is created to delegate tasks and identify goals to reach throughout the patient's admission.

Once the initial meeting of the patient is complete, the treatment team meets to discuss different perspectives and "brainstorm" approaches to take while treating the patient. The providers will then discuss certain medications that could be prescribed to aid in the stabilization of the patient. Next, a finalized PRP is created to ensure clarity on team member roles and patient goals. The patient will then be administered specific medications determined to have the greatest effect on progression throughout the treatment plan. Once the patient has been stabilized and is deemed no longer a danger to themselves or others, they will be discharged and referred to an outpatient community mental health center for continued treatment. Ongoing

tasks throughout the patient's stay are weekly notes, nursing assessments, discharge planning, and encouragement for participation in group therapy sessions on the unit.

Intervention Process and Implementation

Once the patient was transported to the unit she would be residing on, she is described as presenting with symptoms of immobile catatonia. Catatonia is a symptom of some serious mental illnesses where the patient will exhibit out of the ordinary movements, most of the time involuntary. There are two types of catatonia, immobile and stupor. Immobile, as the name suggests, is a lack of movement seen in the patient, extending to not eating, drinking, and speaking. Stupor catatonia is the opposite, defined as involuntary movements that are exaggerated. In order to determine whether the patient had catatonia, the treatment team decided to try an Ativan Challenge on the patient. This challenge consists of administering 2mg of Ativan to the patient. If they are catatonic, an improvement in motor function and energy levels will be seen. If the patient is not catatonic, no change will be noted in the patient after the injectable. After the Ativan was injected, it is noted that the patient started to improve regarding her movements, response to external stimuli, and eye contact. Next, the Bush Francis Catatonia Rating Scale (Appendix B) was completed to determine the level of severity the patient's catatonia presented as. The results of this challenge and assessment allowed the treatment team to see that catatonia was an apparent symptom of her illness and the next steps for treatment could be discussed.

Being that the patient was in a catatonic state for the first three days of admission, much of the psychosocial assessment that was conducted required heavy reliance on collateral information. Patient A is an adult and is her own guardian. With this being taken into consideration, consent is required for any communication of her care to be released or shared outside of the hospital. During the admissions process, the admitting provider was able to gain

consent for her mother to be called. This information is passed to the social workers, and they begin to make the collateral calls. When speaking with the mother, there are a variety of topics that are to be discussed (Appendix C). Collecting collateral information is a primary way that the treatment team can obtain needed information or clarify information provided to gain a better insight into the preceptory factors playing a role in the patient's admission. Through this, we were able to learn that the patient had a recent episode on a smaller scale earlier this year. This information allows us to see the progression of the illness and what changes in the patient's life may have occurred that could have a direct effect on the behaviors being exhibited. Not only this, but collecting collateral information allowed us to "fill in the gaps" of the psychosocial assessment where information could not be applied from the patient's chart record.

Regarding interprofessional practice, each patient at the facility is discussed during daily treatment team meetings. During these meetings, each member of the team is present and gives insight on the treatment and progression of the patients on the unit. For Patient A, there was a specific concern raised by nursing staff about her eating and drinking. Being that an individual needs to eat and drink for required nutrients, a referral was sent to the dietary department (staffed with dietitians) for a different perspective on what could be done to alleviate this from becoming a bigger issue. It was recommended that the patient be prescribed a diet consisting of Ensure protein drinks and snacks offered at bedside. After several days involving this diet, the patient reported that the Ensure drinks were easier to drink and keep down. This opened an avenue for input from the patient on what she could and could not ingest at the moment. Her recommendations of different soups were added to her diet in hopes that the increase in food intake would continue.

As her hospitalization continued, Patient A started to "open up" more when asked questions, offering a greater level of insight and detail to her answers given. She spoke to the providers about her energy level, stating that she was starting to feel drowsy often. This led the

providers to discuss in the treatment team meeting possible changes to her medications as drowsiness is a known side effect of Ativan. Upon discussion with the other members of the team, it was decided to lower her dosage to 1mg of Ativan instead of 2mg. This was a slight change, but it was needed to aid in Patient A continuing to stabilize while also allowing her to gain her energy back to normal levels. Zyprexa (Olanzapine) was also added to her medication regime to aid in stabilizing her mood while tapering her Ativan dosage. The treatment team continued to encourage participation in group sessions offered on the unit to accompany the implementation of medication. Patient A agreed and was reported to attend two out of four groups a day.

After Patient A's medication regime was changed, she was observed and monitored for two days to ensure the response her body was giving to the change was therapeutic. This is when discharge was beginning to be discussed. The treatment team believed that she was no longer a danger to herself or others and the behaviors she was exhibiting were consistent with the baseline criteria outlined by her mother during the collateral call. In order to move forward with the discharge planning, it was discussed the need to check the patient's medication levels in her blood to confirm that the medications she has been administered were at a therapeutic level within her body. An order was written to do so, and this was administered by the hospital phlebotomist. The test came back showing that the medications were within the therapeutic range, making the treatment team more comfortable moving forward with her discharge.

Discharging a patient from ESH is reliant on the stabilization of the patient, confirmation of disposition (where they are going), and outpatient service availability. In regard to Patient A, she was stabilized, and it was confirmed by her mother that she was able to return to her home once she was ready for discharge. Given that the patient did not utilize outpatient services prior to her admission, a referral was needed in order to ensure the continuation of services once out of the care of ESH. The patient resided in Franklin County in Kentucky and based on the

catchment of CMHC's her county falls under New Vista as their mental health provider. A referral was made by the social work department in order to set up follow-up care appointments. Two appointments are made during this process. The first is a therapy appointment that is required to be made within seven days of the patient's discharge date. The second is a medication management appointment that is typically scheduled within 30 days of discharge, being that we call the patient's pharmacy for a 30-day supply to be prescribed. When scheduling with New Vista, they require information such as insurance, date-of-birth, reasoning for admission, and any medications the patient will be prescribed a discharge. All of this information is provided by the social worker assigned to the patient in a confidential interaction between the agency and the social worker themselves to protect the protected health information of the patient. Patient A was discharged on 11/11/2022 with all of her belongings and she was given her discharge packet containing information on her medications and upcoming appointments.

Analysis and Report on Interventions Involved

Looking at the outcomes of the interventions taken in the case of Patient A, we are able to see the shortcomings and successes. Beginning with the Ativan Challenge, there was significant improvement seen once the injectable was implemented in the patient's physical movements and energy level. We were able to confirm that she was in a catatonic state based on her response to the medication. An area of improvement that could be added to this aspect of her treatment was the length of time that she was kept on the 2mg dosage of Ativan. Patient A informed the treatment team of her lowered energy levels and drowsy feeling that she was experiencing. This side effect of the medication should have been monitored by the team in order to avoid this type of feeling from occurring. A change to the dosage earlier could have shortened her admission time frame.

Within all treatment plans created at ESH, the utilization of group therapy sessions are included. Studies have shown that individuals who are involuntarily hospitalized and attend group psychotherapy have lower rates of readmission than those who did not participate in the group setting (Silverberg, 2010). The groups that are available for participation at ESH consist of a curriculum revolving around coping skills, reflection, and aspects of rehabilitation therapy to act as an accommodating part of the treatment plan. Once Patient A was out of her catatonic state, the encouragement to participate in these groups began. We felt that the lessons presented during these times would be especially beneficial for her given her age, situation, and history. Being that we are unable to force group participation, the choice to attend is solely on the patient. When Patient A began attending, the treatment team and I could see a difference in her level of insight regarding her diagnosis. She was beginning to use terminology to explain how she was feeling without becoming tangential and she expressed her plan to utilize coping mechanisms not previously understood by her in her life outside of the hospital. Ultimately, the utilization of group psychotherapy was successful in the case of Patient A as she was able to learn new coping skills and express her desires/feelings in a way that is clearly understood and replicated.

Discharge planning is a major aspect in the treatment plan created for each patient. The discussion about discharge begins on the first day of admission, as it is the goal of hospitalization to aid the patient in being able to live a more independent and stable life outside of the hospital. Patient A was a simple case as far as discharge is concerned. The treatment team was able to confirm her disposition on the first day of her admission and being that the catchment for CMHC's is set in stone, New Vista mental health services were already allocated for her utilization once stabilization was reached. The environment that a patient is in after an involuntary hospitalization is critical for the continuation of the patient's stable wellbeing. Patient A was discharged to return to her mother's house where her social support system is located

with all the information needed to be successful. Follow-up appointments were made with New Vista for the continuation of services and her mother was notified of these to ensure compliance by the patient. Overall, the discharge planning for Patient A was successful.

Laws and Policies Utilized

As with all agencies, ESH also provides services under certain policies and regulations. One in particular that is implemented in every case at the hospital is KRS 202A.026. This statute outlines the regulations involved in involuntary hospitalization (1982). Under this revised statute, individuals are evaluated by mental health professionals to determine the need for involuntary hospitalization in the state of Kentucky. The use of KRS 202A.026 is used continuously throughout the state of Kentucky. The Kentucky Department of Information and Technology Services Research and Statistics (2022) listed in a report that KRS 202A.026 had been cited 12,508 times to involuntarily hospitalize an individual for their own safety and/or the safety of others.

When an individual is hospitalized involuntarily, there are three different ways in which this can be done. The first is the previously mentioned KRS 202A.026, which lays a foundational starting point for individuals and clinicians to hold someone within a psychiatric hospital. Another statute that is used, and gets confused with KRS 202A, is KRS 202B.100. This revised statute is specific for individuals who have an intellectual or developmental disability (IDD) (2012). Oftentimes, individuals who have IDD have behaviors that mimic those of individuals suffering from psychosis. When patients are brought to the hospital under KRS 202B.100, it is often for behavioral disturbances. These can include acting out behaviors such as: property destruction, aggressive behavior, violence, and inappropriate sexualization. Given that these individuals are considered a vulnerable population (“Vulnerable Populations”, 2018) there are more safeguards in place for their safety and upholding of their rights. The final type of involuntary hospitalization

that is utilized is KRS 504.080 which outlines the requirements for individuals currently incarcerated to be examined and evaluated by a psychologist or psychiatrist to find the person fit to stand trial (2005). Although each of these types are intended for a specific type of patient, they are all in place in order to protect the safety of the patient themselves and those in the community.

Critical Analysis of Social Work Values and Approaches

Working with individuals who have a serious mental illness (SMI), it is important to understand that although their rights are technically being hindered through involuntary hospitalization, they are still human. In the social work profession, we practice under a set of core values that instill certain ideations into each clinician (NASW, 2021). These values help to shape and outline the ways in which services are provided and continued within any and all agencies. Strategies and approaches are often based on these values and aid in providing effective and ethical services.

Dignity and worth of a person. Although the patients at ESH come with a multitude of different issues, both medical and psychosocial, they are still obligated to receive treatment that does not devalue them as a person and member of society. When working with Patient A, it was critical that she see the treatment being provided in a respectful and trusting light. As a young woman in our care, there are certain needs that are to be met. Two are access to feminine hygiene products and the shaving of her legs. As a treatment team, we recognize that patients are more likely to benefit from services when they feel comfortable. In order to do this and uphold Patient A's dignity, it was ensured that she had full access to feminine hygiene products while in our care. Along with this, Patient A approached the treatment team asking to shave her legs. Although she was admitted for suicide ideation, her treatment had progressed to the point where certain things could begin to be given back to her. Knowing this and how well she was

doing, the treatment team decided to grant a shave order (physician order allowing for a patient to use a razor while supervised). These actions aided in upholding her dignity while receiving treatment.

Importance of human relationships. Within all cases throughout the social work profession, human relationships are at the core of each encounter. Whether these relationships are between the worker and the patient or the patient and their support system, they all contribute to the progression, regression, and creation of treatment plans. Regarding Patient A, she presented to the hospital with a very strong support system of family and friends. When speaking with the patient's family it was critical that we emphasized the importance of their involvement in treatment once she was discharged. Studies show that family involvement within a patient's treatment is significantly associated with higher rates of medications adherence, attendance to outpatient appointments, and ongoing progression of stabilization (Haselden et al., 2019). Not only is family involvement important, but the relationship between the patient and the treatment teams needs to be one that is progressive and trusting in order to facilitate a healthy environment. In order to do this, social workers and the providers work to ensure the patient is agreeable to anything proposed within the treatment plan. This gives Patient A a sense of autonomy in her own care, thus increasing the likelihood of a quick stabilization time.

Transpersonal and systems theory. Although speaking with Patient A was the first step in treatment, it is important to utilize specific social work perspectives and theories to help organize our thoughts and approaches. Systems theory describes the way in which different connections within a person's life affect their behavior (Russiano, 2020). Given that the psychosocial assessment aided us in discovering that Patient A had a strong support system, we were able to see which connections in her life were strong and which ones needed improvement. Many of the connections that she had were strong, therefore we could assume that a large involvement from family and friends would be beneficial post-discharge. We found

that her connection to community mental health resources needed improvement and was able to facilitate the initial utilization through a referral to outpatient services at discharge. The utilization of outpatient services is crucial to continued progression; however, Patient A is not always going to be with her therapist. Knowing this, I utilized the transpersonal theory to aid in introducing the patient to specific coping skills she can use when she finds herself in situations where her mood starts to shift. Transpersonal theory looks at an individual through a holistic stance to focus on the "relationship between the mind and the body" (Russiano, 2020). In order to do this, I spoke with the patient about focusing on her five senses to calm herself down and center her thinking (Figure 1).

Consideration of safeguarding, risk, needs, strengths

As with all interventions, there are specific risks to be considered before the implementation phase. One specifically noted in the case of Patient A was a possible reaction to certain medications. Patient A had never been prescribed a regular regime of psychotropic medication, meaning that there was not a control reaction to predict how she would react to certain medicines. This is common among patients who are experiencing their first break as they have not been treated for their psychiatric needs before. Ultimately, it is like starting from scratch and this can be very difficult when finding the right combination of medications to administer.

The needs of the patient in the care of ESH staff are of utmost priority, especially in regard to discharge planning. Patient A presented with more strengths than needs, but one in particular that we could assist with during her care was her access to outpatient services. As discussed above, all patients are scheduled follow-up appointments upon discharge. Patient A did not utilize any community resources prior to her admission to the facility. The only reported utilization that she presented with was the counseling center at her previous university. Patient

A was referred to New Vista for outpatient treatment being that we were able to schedule both a therapy appointment and a medication management appointment with the same facility and Franklin County falls under New Vista's catchment area.

Patient A presented to ESH with many strengths that play in her favor when it comes to stabilization and continued progress. She has stable housing, a slight income, and a major social support system. These are attributes that all patients are worked with to achieve either before or after their hospital discharge. The existence of these strengths can play vital roles in Patient A's success outside of an inpatient setting. Her stable housing helps to alleviate certain stressors that could arise, her support system can be used for reflection and encouragement throughout her continued treatment, and her income (like her housing) aids in providing a more stable environment for her to continue to improve and stabilize.

The Patient Perspective

Many patients who are admitted to ESH are done so in an involuntary manner. This means that they were petitioned by friends, family, or the court system to receive psychiatric treatment regardless of their willingness to do so. As one can imagine, being hospitalized against your will can be a very confusing and fearful time. In the case of Patient A, there was a sense of mistrust that was apparent throughout the initial stages of her hospitalization. As discussed, prior, she became increasingly guarded during the admissions process, endorsing paranoia and continued suicide ideation. Once taken to the unit, Patient A went into what we believed to be a catatonic state. After the Ativan Challenge was administered, she began to become more lucid, but still was very wary of providing information or eating. This is common among catatonic patients as they are essentially waking from a sort of sleep, confused and unaware of the events happening around them (Jacklyn Mortenson, PA-S, personal communication, November 14, 2022).

Over the course of her admission, Patient A became more aware of her situation and as her progression towards stabilization furthered, we were able to see that she was less guarded when approached by staff. As I have been able to witness while employed at ESH, patients will begin their admission exhibiting the same type of behavior as Patient A did, mistrusting and paranoid. As they work through their treatment plans, insight on their illness and the services being provided becomes clearer, making way for trust and rapport to be built.

Interprofessional Practice Perspective

Working within an interprofessional team can provide the most effective and efficient services a patient can be offered. At ESH the treatment team is composed of the providers, social workers, nurses, rehabilitation therapists, occupational therapists, psychologists, and mental health associates. Each member of the team provides new and innovative perspectives to add depth to discussion and the treatment plan being created. Given that not all the issues patients experience are psychiatric or psychosocial, other disciplines are required to address these, so they are not exacerbating the psychiatric and psychosocial problems that are apparent.

As a member of the interprofessional team, it was imperative that I provided input that was constructive, progressive, and effective. In order to do this, I listened attentively when each of the team members spoke in respect to their chosen professions. Doing this provided the opportunity to take what they were including into consideration and apply certain social work aspects to it to ensure that the patient's rights are being upheld and that all needs are being met. This also allowed me to understand where my services were needed from the social work perspective. Oftentimes, psychosocial issues may not become apparent until other disciplines report their findings on the tests they conduct. This is not the fault of the psychosocial assessment missing something, but rather as time progresses throughout the patient's

admission, more information can be uncovered that “connects the dots” for different members of the team. As a social worker on the team, my main focuses were to ensure practice was being conducted ethically, the rights and obligations of the patient were being upheld, psychosocial issues were discovered and resolved, and aftercare services were set up for once the patient is discharged.

From a provider and nursing perspective, patient cases are approached similarly regardless of the situation and then changed depending on the extent or severity of the symptom burden being portrayed. As a provider, it is easy to become linear in the treatments being provided, but it is also important to remember that signs and symptoms of certain diagnoses can resemble each other (Dr. Charles Shelton, personal communication, November 16, 2022). This is where research and prior knowledge come into play to aid in cultivating a specific treatment plan (from a medical standpoint) for specific patients. As a social worker, I would not attempt to recommend medications and dosages for the treatment plan implementation because it is not within my scope of practice. Providers and nurses can do so being that their training and education allows for this. This also extends to the psychologist as they can diagnose and recommend treatment.

Conclusion

To summarize, Patient A was treated at ESH for suicide ideation and delusional thought. She was provided with medication administration, therapy, and psychosocial assessments to ensure issue alleviation. When admitted to the facility, she was exhibiting paranoia and as her treatment progressed her insight on her situation returned allowing for a trusting relationship between her and the treatment team to grow. The success of the case can be attributed to the work done by the interprofessional team. Progression would not have been achieved without the inclusion of multiple perspectives and knowledge bases as the handling of a first break can be

delicate. All members of the team were utilized within their scope of practice and the patient was given an opportunity to return home with her family and friends to live a full and stable life. Although this outcome can be deemed as not typical, it is one that is not possible without the participation of the patient in their own treatment. Ultimately, the treatment team can prescribe as much medication as they please and encourage participation in group psychotherapy, but it is up to the patient to be adherent and comply with the recommendations being made.

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Figure 1

Grounding Yourself Exercise

Note. Instructions listed for grounding exercise. *Grounding your body and mind*. Strong4Life. (2022). Retrieved November 15, 2022, from https://www.strong4life.com/en/emotional-wellness/coping/grounding-your-body-and-mind

Appendix A

Action	Timeframe/Frequency	Purpose	Responsible Party
Admission evaluation	Day 0; x1	Indicate level of need for admission and gain initial background knowledge as starting point for the treatment team.	Admissions providers/nurses
Psychosocial Assessment	Day 1-3; x1	Gather information to support reasoning for services, needed assistance, and future referrals.	On unit social worker
Legal status confirmation	Day 1-3; As Needed	Determine legal status of patient in regard to guardianship/legal issues	Social Worker
Prescribing of medication	Ongoing; As Needed	Support symptom burden regression through psychotropic medication.	Providers
Administration of medication	Ongoing; As Ordered	Support symptom burden regression through psychotropic medication.	Providers/nurses
Collateral information collection	Day 1-3; As Needed	Obtain needed information/clarify acquired information with the support system of the patient.	Providers/social workers
Creation of Initial Personal Recovery Plan	Day 1; x1	Assign specific tasks and goals for each member of the	Assertive Treatment Coordinator

		treatment team based on presenting problems	
Finalization of Personal Recovery Plan	Completed by Day 10; x1	Review of plan by all treatment team members to establish working goals and assignments.	Active Treatment Coordinator
Group Therapy Sessions	Offered on Day 1; 4 times a day (voluntary)	Provide specific time for group therapy with other patients.	Rehabilitation Therapist/Social Worker/Psychologist
Weekly Progress Notes	Every seven days; As Needed	Documented check-in with patients to determine progress and adherence to treatment plan.	Providers/Social Workers/ Nursing Staff
Nursing Assessment Notes	Everyday; As Needed	Document eating habits, medication adherence, and acting out behavior occurrences.	Nursing Staff
Discharge Planning	Ongoing; Throughout treatment	Determine where the patient will be discharged to and what services are available for referral.	Treatment Team; primarily Social Workers
Referral for Outpatient Care	End of Admission; x1	Provide needed information to outside agencies for scheduling of post-discharge care.	Social Workers

Appendix B

Bush-Francis Catatonia Rating Scale

Severity Score (Number of points for items 1 -23) _____
Screening Score (Presence or absence of items 1 – 14) _____
Number of items 1-23 _____

Patient: _____ Date: _____ Time:_____ Examiner: _____

1. Immobility/stupor: Extreme hypoactivity, immobile, minimally responsive to stimuli.
0 - Absent.
1 - Sits abnormally still, may interact briefly.
2 - Virtually no interaction with external world.
3 - Stuporous, non-reactive to painful stimuli.

2. Mutism: Verbally unresponsive or minimally responsive.
0 = Absent.
1 = Verbally unresponsive to majority of questions; incomprehensible whisper.
2 = Speaks less than 20 words/5mins.
3 = No speech.

3. = Staring: Fixed gaze, little or no visual scanning of environment, decreased blinking.
0 = Absent.
1 = Poor eye contact, repeatedly gazes less than 20 s between shifting of attention; decreased blinking.
2 = Gaze held longer than 20 s, occasionally shifts attention.
3 = Fixed gaze, non-reactive.

4. Posturing/catalepsy: Spontaneous maintenance of posture (s), including mundane (e.g. sitting or standing for long periods without reacting).
0 = Absent.
1 = Less than I min.
2 Greater than one minute, less than 15 min.
3 Bizarre posture, or mundane maintained more than 15 min.

5. Grimacing: Maintenance of odd facial expressions.
0 = Absent.
1 = Less than l0seconds.
2 = Less than 1 min.
3 = Bizarre expression(s) or maintained more than 1 min.

6. Echopraxia/echolalia: Mimicking of examiner's movements (echopraxia) or speech (echolalia).
0 = Absent
1 = Occasional.
2 = Frequent.
3 = Constant

7. Stereotypy: Repetitive, non-goal-directed motor activity (e.g. finger-play, repeatedly touching, patting or rubbing self); abnormality not inherent in act but in its frequency.
0 - Absent
1 - Occasional.
2 - Frequent.

3 - Constant.

8. Mannerisms: Odd, purposeful movements (hopping or walking tiptoe, saluting passers-by or exaggerated caricatures of mundane movements); abnormality inherent in act itself.
0 - Absent
1 - Occasional.
2 - Frequent.
3 - Constant.

9. Stereotyped & meaningless repetition of words & phrases (verbigeration): Repetition of phrases or sentences (like a scratched records).
0 - Absent.
1 - Occasional.
2 - Frequent, difficult to interrupt.
3 - Constant.

10. Rigidity: Maintenance of a rigid position despite efforts to be moved (exclude if cog-wheeling or tremor present)
0 = Absent.
1 = Mild resistance.
2 = Moderate.
3 = Severe, cannot be repostured.

11. Negativism: Apparently motiveless resistance to instructions or attempts to move/examine patients. Contrary behavior, does exact opposite of instruction.
0 - Absent
1 - Mild resistance and/or occasionally contrary.
2 - Moderate resistance and/or frequently contrary.
3 - Severe resistance and/or continually contrary.

12. Waxy flexibility: During repositioning of patient, patient offers initial resistance before allowing him/herself to be repositioned, similar to that of a bending candle. (also defined as slow resistance to movement as the patient allows the examiner to place his/her extremities in unusual positions. The limb may remain in the position in which they are placed or not)
0 - Absent
3 - Present.

13. Withdrawal: Refusal to eat, drink and/or make eye contact.
0 = Absent.
1 = Minimal oral intake/interaction for less than 1 day.
2 = Minimal oral intake/interaction for more than 1 day.
3 = No oral intake/interaction for 1 day or more.

14. Excitement: Extreme hyperactivity, constant motor unrest which is apparently non-purposeful. Not to be attributed to akathisia or goal-directed agitation.
1 - Excessive motion, intermittent.
2 - Constant motion, hyperkinetic without rest periods.
3 - Full-blown catatonic excitement, endless frenzied motor activity.

----------End of Screening Items----------

15. Impulsivity: Patient suddenly engages in inappropriate behavior (e.g. runs down hallway, starts screaming or takes off clothes) without provocation. Afterwards can give no, or only a facile explanation.
0 - Absent.
1 - Occasional.
2 - Frequent.
3 - Constant or not redirectable.

16. Automatic obedience: Exaggerated cooperation with examiner's request or spontaneous continuation of movement requested.
0 = Absent.
1 = Occasional
2 = Frequent
3 = Constant.

17. Passive Obedience (mitgehen): Patient raises arm in response to light pressure of finger, despite instructions to the contrary.
0 = Absent.
3 = Present.

18. Muscle Resistance (gegenhalten): Involuntary resistance to passive movement of a limb to a new position. Resistance increases with the speed of the movement.
0 - Absent
3 - Present.

19. Motorically Stuck (ambitendency): Patient appears stuck in indecisive, hesitant motor movements.
0 - Absent.
3 = Present.

20. Grasp reflex: Striking the patient's open palm with two extended fingers of the examiner's hand results in automatic closure of patients hand.
0 = Absent
3 = Present

21. Perseveration: Repeatedly returns to same topic or persists with the same movements.
0 = Absent.
3 = Present.

22. Combativeness: Belligerence or aggression, Usually in an undirected manner, without explanation.
0 = Absent
1 = Occasionally strikes out, low potential for injury.
2 = Frequently strikes out, moderate potential for injury.
3 = Serious danger to others.

23. Autonomic abnormality: Abnormality of body temperature (fever), blood pressure, pulse, respiratory rate, inappropriate sweating, flushing.
0 = Absent
1 = Abnormality of one parameter (exclude pre-existing hypertension).
2 = Abnormality of two parameters.
3 = Abnormality of three or more parameters.

Appendix C

Patient:
- Patient A; 12.40pm

Collateral received from:
- Patient A's mother, XXX-XXX-XXXX

Guardian:
- Self, mother starting process of guardianship

Presenting Problem:
- Pt is reported to be fine until the past Saturday when she began to "act different."; Pt is reported to not have slept at all until given Ativan at the hospital on Sunday; Responding to internal stimuli began on Saturday 10/29/22 and then worsened on Wednesday 11/2/22; Mother states that pt was "fine" in the hospital until nursing staff brought a tablet for her to speak to someone, this is when she became agitated; Pt became tangential after conversation on the tablet while in the hospital, incoherently; Pt was at XXX and family had to go pick her up from the school due to a "mental breakdown."; Pt is reported to have neglected all responsibilities right before "mental breakdown" at school; Pt has had multiple deaths in her family over the last year, four specifically; Pt never endorsed SI to family or in the family home, only at the hospital and ESH; Pt isolated herself and distanced herself from friends and family after school incident; Pt is usually described as outgoing, family loving, and very happy.

Family History:
- No consistent relationship with father.
- Great-Aunt has reported mental illness, but dx is unknown.
- Grew up in Frankfort, KY

Psychiatric History:
- Previous mental episode in April.
- Admitted to Frankfort Regional Medical Center prior to ESH.

Medical History/Concerns:
- None reported.

Community Resources:
- Followed up with Kelly Dycuf.

Substance Abuse:
- None indicated.

Legal Issues:
- None reported.

Income:
- None reported.

Guns/Safety Concerns:
- None reported.

Other:
- None.

Disposition:
- Pt can return to mother's house upon discharge.

COVID Vaccine:
- Yes, no boosters reported though.