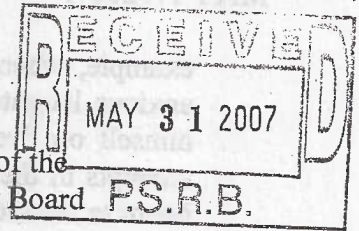


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GENDER: Male
MARITAL STATUS: Single
RACE: Caucasian
COMMITMENT STATUS: Revocation under jurisdiction of the
Psychiatric Security Review Board
PRIOR LIVING ARRANGEMENT: Other



NURSING ASSESSMENT—OVERALL BEHAVIOR IN THE MILIEU: The patient tends to spend a lot of time in his room. He sleeps a lot during the day and then is up at night. He has declined to attend groups over the last few weeks.

FUNCTIONAL ABILITIES

	INDEPENDENT	NEEDS ASSISTANCE
Grooming and Hygiene	X	
Toileting	X	
Mobility	X	
Requires:	hands on	cane walker
Basic household Skills:	X	
Risk of Falls	None-X Low	Medium High

EDUCATIONAL AND TEACHING NEEDS: The patient would benefit from education regarding mental illness and benefits of medication.

ADVANCE DIRECTIVE REVIEW: The patient was offered the opportunity to have information about Advance Directives.

CURRENT MENTAL STATUS—CHANGES OBSERVED: The patient appears as a young Caucasian male, casually groomed. He has some unusual mannerisms of his face which appear to perhaps be nervous twitches or tics. These are accompanied by movements of his hand, slightly tugging or pulling at different parts of his face. His tongue does not display any abnormal movements and the movements are not particularly suggestive of an extrapyramidal symptom or tardive dyskinesia. Instead, they appear to be nervous mannerisms. The patient's mood is variable. At times he describes himself as anxious or depressed. Affect is variable and at times seems somewhat inappropriate. For

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example, when anxious, he can laugh in a manner which seems somewhat odd even for anxious laughter. The patient does report suicidal ideation. He has thoughts of setting himself on fire at a gas station. His suicidal ideation is chronic. He has had suicide attempts in the past and thoughts of suicide frequently come to his mind. He denies any intent to immediately attempt suicide in the near future and can give no particular plans for how to actually attempt suicide in the hospital. There are no homicidal ideations. The patient denies auditory or visual hallucinations. There are no delusions noted. However, the patient often appears rather fearful. Some of those previously described mannerisms appear almost as if he is guarding himself from some sort of attack. He describes himself as being fearful of social situations. He worries that he will be unable to express himself if asked to speak in a group setting. The patient is generally alert and oriented. Please see the section below regarding cognitive status.

CURRENT MEDICATION AND MEDICATION TRIALS AND RESPONSES

Paroxetine (Paxil) 20 mg p.o. q.a.m.
Lamotrigine (Lamictal) being tapered to discontinuance; currently at 50 mg
p.o. b.i.d.
Celecoxib 100 mg p.o. b.i.d.
Minocycline 100 mg p.o. q.a.m.
Opti-Free Express disinfecting solution, own supply, use as directed, may keep at
bedtime
Opti-Free rewetting drops, own supply, use as directed, may keep at bedside
Quetiapine fumarate 400 mg p.o. q.h.s.
Multiple vitamins with minerals, 1 tablet p.o. q.h.s.
Acetaminophen 325 mg p.o. q.4-6h. p.r.n. musculoskeletal pain
Custom eyeglass cleaner, own supply, use as directed each day p.r.n.
Diazepam 5 mg p.o. q.8h. p.r.n. agitation or panic attack, not to exceed two doses
in 24 hours
Diphenhydramine 50 mg p.o. q.6h. p.r.n. extrapyramidal symptoms or allergies
Quetiapine fumarate 50 mg p.o. q.h.s. p.r.n. insomnia, may repeat in one hour if not
asleep
Hypoallergenic soap bar, use for bathing
Miconazole nitrate cream 2%, apply to areas of athlete's foot b.i.d. until resolved

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The patient transferred to Unit 41A on April 5, 2007. Following his transfer, it was noted that he was having difficulties with hypertension and at the suggestion of Jacqueline Logan, MD, in the medical clinic a decision was made to taper and discontinue the Effexor (venlafaxine) which he was receiving as an antidepressant medicine. Following this, the patient then began to refuse Lamictal as he felt it was not helpful for him. The patient was cautioned that abruptly stopping Lamictal could place him at risk for having a seizure. He then agreed to have a tapering schedule on the Lamictal. The patient then reported depressive feelings and after much discussion there was a decision to start paroxetine at 20 mg p.o. q.a.m., this began on May 15, 2007. During this time period when all these medication changes were happening, there were doubts about the patient's ability to give informed consent for psychotropic medications. At one point when an attempt was made to discuss his medicines with him, he simply began laughing at this physician. As such, an outside consulting physician was called in order to help assess whether the patient was competent to give informed consent for medications. The opinion of George Suckow, MD, was that the patient was indeed competent to give informed consent.

In meeting with the patient today, he talks about a desire to have the quetiapine discontinued. It was discussed with the patient that it is not advisable to change so many medications over such a short period of time. The patient was agreeable to continue with the quetiapine for the meantime in order to help sort out any changes in mental status which might be due to the paroxetine, the discontinuance of Lamictal, the discontinuance of the venlafaxine, and the discontinuance of the propranolol which was no longer needed after the venlafaxine was discontinued.

Furthermore, there was discussion with the patient that if his diagnosis of bipolar disorder is accurate, there is a risk to receiving antidepressant medication without a mood stabilizer or antipsychotic medicine, the risk being the production of a manic episode. The patient doubts that he has a diagnosis of bipolar disorder and, indeed, there is some reason to think that the bipolar diagnosis might not be accurate. Please see the diagnostic section for further information on these issues.

MEDICAL/HEALTH ISSUES: The patient had some hypertension, which was thought to be secondary to Effexor. The Effexor was tapered and discontinued; so far the patient has not a recurrence of the hypertension. He takes minocycline for an acne problem.

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CURRENT DIAGNOSES (DSM-IV-TR/ICD-9-CM)

- Axis I Bipolar disorder, most recently depressed
 Posttraumatic stress disorder
 Attention-deficit hyperactivity disorder (history of)
- Axis II Personality disorder, not otherwise specified, with borderline traits
- Axis III History of temporomandibular joint problem
 Acne
- Axis IV Psychosocial and Environmental Problems
 - NOT PROVIDED
- Axis V Global Assessment of Functioning (GAF)
 Current: NOT PROVIDED

Regarding the above diagnostic listing, the bipolar disorder is a diagnosis arrived at by Lorraine Skach, MD, prior to his transfer to Unit 41A. Dr. Skach gave considerable thought to this diagnosis as outlined in her October 13, 2006, Progress Note Update. Furthermore, after the patient's arrival on Unit 41A, I interviewed the patient and consulted with his grandmother, with the patient's informed consent. It was very difficult for me to obtain a clear-cut history of a manic episode from the patient or his grandmother. The patient tended to doubt whether he had a diagnosis of bipolar disorder. The patient's grandmother was confident that he has a bipolar diagnosis and that it is accurate. However, the grandmother did not give a clear-cut history of having had a manic episode. She did report that the patient was often up much of the night and that he tended to spend his money somewhat carelessly.

The patient reports a history of attention-deficit hyperactivity disorder and asks if he can receive a medication for this problem. He says that he took Ritalin in the past. In order to corroborate this history I contacted the patient's grandmother with his permission and the grandmother indeed reports a history of attention-deficit hyperactivity disorder and treatment with Ritalin. She reports that the Ritalin was helpful for him except that he had some difficulty with side effects. She says it made him feel too hot. At this point there is a plan to help clarify any ongoing attention-deficit hyperactivity disorder symptoms through psychological testing.

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Other diagnostic considerations for this patient include the possibility of social phobia, agoraphobia, and panic disorder with agoraphobia. Schizotypal, schizoid, and avoidant personality disorders could also be considered in addition to the borderline personality traits. Much of the history obtained from the patient's grandmother has to do with the patient isolating himself in his room. She says that whenever other members of the family came home the patient would immediately retreat to his room and avoid interacting with them.

It is noted that the patient has also had a diagnosis of schizophrenia in the past. Schizophrenia, psychotic disorder, not otherwise specified, and schizoaffective disorder could also be considered as diagnoses. As such, the diagnostic picture at this time is quite unclear. Indeed, the diagnosis may be evolving over time as we learn more about the patient's presentation and history. He is still rather young at age 22.

SOCIAL HISTORY UPDATE: At this time there is no additional information beyond the psychosocial baseline history which is available in the chart. The patient has given permission to contact his grandmother; and although her reports of his history are not particularly precise they do help to corroborate some historical elements and diagnostic issues.

HAS THE PATIENT BEEN IDENTIFIED AS READY FOR DISCHARGE: Yes
No-X

If so, when?

PRINCIPAL BARRIERS TO DISCHARGE OR TRANSITION TO LESS RESTRICTIVE ENVIRONMENT: There are several barriers to discharge at this time. These include diagnostic uncertainty, a lack of a stable medication regimen, and the patient's noninvolvement in treatment, nonattendance at group therapy.

DISCHARGE READINESS PLAN: In meeting with the patient today, he was encouraged to at least attend 10 hours of programmed activities a week. The usual standard is 20 hours. Such programmed activities could include involving himself in the vocational services program, attending psychosocial treatment groups, such as Medication Education Group, or simply going on recreational activities with staff. The patient thought that he could perhaps attend at least 10 hours of programming a week. It is possible that

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the patient has a social phobia disorder and it may be that this is inhibiting his ability to participate in treatment.

When asked if the patient would like to be discharged from the hospital, the patient states that he is not so sure. In fact, he sees more disadvantages to leaving the hospital than to staying in the hospital. He worries about how he would need to interact with others when outside of the hospital and feels that life outside of the hospital has not gone especially well for him.

DISCHARGE PLAN REQUIREMENTS: The patient will need to have a placement site approved by the Psychiatric Security Review Board and acceptable to the patient himself. The acceptance by the patient himself may be the more difficult matter as the patient is rather reclusive and may have a considerable amount of anxiety over being placed in the community.

OVERALL TREATMENT PROGRESS: Currently, the patient is not making very good progress in his treatment. It may be that he is going through an adjustment period to Unit 41A. Indeed, he is beginning to develop a good working relationship with his case monitor. However, he has also dropped out of treatment programming. It is possible that his being taken off of the antidepressant, Effexor, has resulted in him spending more time in his room and being less interactive through group attendance. Hopefully, the initiation of Paxil will be of some benefit to him in this regard.

TESTING PERFORMED: Psychological testing completed during the review period included objective and projective personality measures. Results suggest that the patient does have a negative and unstable self-image and poor interpersonal relationships. The results suggest an overall depressed mood as well as affective and behavioral lability as that often associated with borderline personality disorder as well as narcissistic traits.

Neuropsychological and intelligence testing has not been done but will be scheduled along with the assessment for attention-deficit hyperactivity disorder. At this time his intelligence quotient can be considered at least normal.

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PROPOSED CHANGES IN TREATMENT CARE PLAN: In meeting with the patient today he was agreeable to meeting with Michelle McGraw-Hunter, PhD, for individual therapy. We are hopeful that these weekly individual meetings will help us keep track of the patient's mental status. Of particular concern are his chronic suicidal ideation and his reluctance to talk about such matters. We would not want to miss helping him overcome any acute suicidal crisis if he were to be in such a crisis.

PROBLEM BEHAVIORS AND RISK ASSESSMENT: Frank Seibel, PsyD, completed portions of a Risk of Violence Assessment in February 2006. At that time the results suggested a prevalence of violence-related factors associated with a difficult childhood and adolescence. The patient's current behavior and that reported on the assessment indicate that he is doing reasonably well in regard to treatment though not engaged in the therapeutic aspects of recovery.

PARTICIPATION IN REHABILITATION SERVICES DEPARTMENT (RSD) TREATMENT GROUPS, COMMUNITY INTEGRATION ACTIVITIES AND/OR VOCATIONAL SERVICES: The patient had been involved in the Benchwork program here at Oregon State Hospital. However, in March 2007 the patient was struggling in that program and has since dropped out of it. His average productivity was listed as 74% with total points scored 71. For March 2007 he had only attended three out of 15 Benchwork sessions available.

PROGRESS TOWARD GOALS ON TREATMENT CARE PLAN: The patient is not making good progress towards his goals on the Treatment Care Plan as he has dropped out of psychosocial treatment offerings. Hopefully, we will be helping him get back on track and begin attending at least some of the psychosocial treatment groups available. It will be important to keep in mind that the patient may have a social phobia which is impairing his interactions on this basis. Perhaps the individual sessions with Michelle McGraw-Hunter, PhD, will be more tolerable for him.

PARTICIPATION IN MENTAL HEALTH SPECIALIST GROUPS: The patient joined the Relapse Prevention, Anger Management, and Cook Your Own Breakfast Groups upon transfer to Unit 41A. He continued to enjoy Cook Your Own Breakfast Group but declined attending the Relapse Prevention and the Anger Management Groups thereafter.

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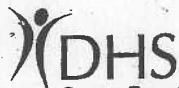
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PARTICIPATION IN SCHOOL: The patient had been attending Quest School at Oregon State Hospital in order to learn Japanese. However, he dropped out of the Japanese classes. He does still attend some classes on a variety of topics, such as social studies.

John W. Baker, MHT-2
John Baker, MHT-2
Case Monitor

Jamal Al Awaj, MHT-2
Jamal Al Awaj
Mental Health Specialist

Donna Bartle RN
Donna Bartle, RN
Nurse

Steven E. Fritz, MD/cm
Steven E. Fritz, MD/cm
Physician

Robert Lundblad, PsyD
Robert Lundblad, PsyD
Psychologist

NOT ASSIGNED
Rehabilitation Services

NOT ASSIGNED
School Representative

Michael Godfrey, MSW
Michael Godfrey, MSW
Social Worker

Michelle McGraw-Hunter, PhD
Michelle McGraw-Hunter, PhD
Unit Director

D. 05/17/07 R. 05/17/07 T. 05/21/07 cc: PSRB

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