June 9TH 2021
Psychiatry
Gagandeep Munday, PA-S
NYC HHC Elmhurst AB11

IDENTIFICATION:

Name: T.K.	Age: 65	PMD: Dr. D
Sex: M	Marital status: Married	Informant: self
Race: Polish	Address: N/A	Reliability: reliable
Nationality: US	Religion: N/A	Referral: EMS

CC: Suicide attempt

HPI

TK is a 65 year old polish and english speaking male, married, self employed as an accountant, domiciled with his wife of 30 years. Has past medical history of gastroesophageal reflux disease, psychiatric history of major depressive disorder and alcohol use disorder, in remission. Patient follows up with outpatient psychiatric treatment for the past 11 years with Dr. K. He endorses no history of past suicidal behavior or suicidal attempts, aggressive behavior, or legal concerns. TK states that he was recently admitted to Mount Sinai main campus, for ~10 days, after being transferred from Elmhurst Hospital Center CPEP on April 30th 2021. At the time the patient had preparatory suicidal behavior, he went to his balcony with the intention of jumping, however his neighbor noticed him and stopped him. He was discharged from Mount Sinai on cymbalta 40 mg daily, klonopin 0.25 mg daily, Naltrexone 50 mg daily, and Seroquel 50 mg nightly.

On May 21st, 2021 patient was brought to Elmhurst psychiatric emergency department by emergency medical services and was escorted by New York City police officers. The security desk at the patient's apartment building called 911 after TK physically assaulted his wife in order to subdue her so that he would be able to jump off the balcony or out of the window of his 9th floor apartment in order to kill himself. TK's wife was brought to Elmhurst medical center's emergency department for treatment of head injuries sustained from his attacks.

On arrival at CPEP, the patient was observed to be depressed with persistent suicidal ideation. He endorsed that suicide was the only way that he had out, and that he needed to "kill his wife" in order to kill himself. Upon assessment at unit AB11 patient reports that he was brought to the hospital for physically assaulting his wife with a cutting board in order to kill himself by jumping off the balcony because he "would not have been able to do it otherwise". States that neighbors and security called 911 due to the noise caused by his wife's screams. Patient endorses that depressive symptoms have been progressively worsening over the past 6 months, and he currently presents with depressed mood, decreased interest in usual sources of enjoyment, decreased appetite, decreased need for sleep, feeling worthless, feeling hopeless, poor energy, poor concentration, feeling miserable increased problems at work, frequent suicidal ideation, and daily suicidal thoughts throughout the day that are moderately difficult to control. States that he

has been planning suicide for the past 1 month, most recent attempt was prior to admission, and before that was 3 weeks ago which resulted in inpatient admission to Mount Sinai. Patient states that he had persistent thoughts about killing his wife because she "is always home" and will keep him from jumping out the window. Additionally, the patient endorses a constant state of anxiety and restlessness for the past month for which he has been using Ativan, provided by Dr. K. He associates the anxiety with increased stress at work and recent difficulty with memory and poor concentration. When asked about his work, TK stated that he was self-employed. When asked if he would have liked someone to help him with his work he responded "no one can do things the way I do or how I like it, I'd rather do it myself which is always will be better in my opinion".

Patient states that he has a supportive family however he does not think that would deter him from committing suicide. Patient is actively suicidal with a plan and intent to do it upon discharge. He is denying any past history of self-harm, and currently denies any intent to harm or kill himself while in the hospital setting stating that he does not have the means to do it here but "would try to do it if he was home alone".

During the interview, the patient was wearing hospital pajamas, is groomed, wearing eye glasses, inconsistent eye contact, soft speech, with a depressed and anxious mood, and was able to sit still but appeared restless. He kept pointing at his chest stating that it was uncomfortable. Had blunted affect and linear thought process.

Denies any history of auditory or visual hallucinations now or in the past. Patient denies any delusions were elicited. Has a history of alcohol abuse, but denies current use of alcohol. Endorses family history of Major Depressive Disorder by mother and sister. Reports being diagnosed with Major Depressive Disorder approximately 10 years ago.

On June 8th 2021 TK was given orders of protection by his wife against home. When approached for an interview, the patient was sitting calmly on his bed reviewing the paperwork. There were no observable signs of distress. He denied active suicidal thoughts, he was future oriented in his thinking. He expressed his wishes to appeal the orders of protection while virtually attending the court hearing on June 9th 2021. Patient denies any willingness towards self harm at this time.

Collateral information from TK's daughter NK: Reports that she and her mother think that TK was released prematurely and that he was still depressed upon arrival back home. NK denies any past episodes of suicidal attempts or other forms of self harm. NK states that she lives nearby but was not at her parent's home when the altercation occurred. She states that her mother needs brain surgery due to the intracranial bleeding that resulted from the assault by TK. NK denies that TK has any past history of violence, abuse, or of any significant marital trouble with her

mother. On June 8th NK told staff that her mother had filed orders of protection against her father, she also states that police told her that TK will be arrested upon discharge.

General

1. Appearance: Mr. K is a medium height, small built, well nourished, casually groomed male. He has male pattern baldness stage 3. He is wearing hospital-provided pajamas and reading glasses. He was actively reading his
2. Behavioral and psychomotor activity: Mr. K appears calm and engaged.
3. Attitude Towards Examiner: Cooperated with examiner and established rapport with the treatment team immediately.

Sensorium and Cognition

1. Alertness and Consciousness: alert, conscious.
2. Orientation: oriented to time place and person
3. Concentration and attention: demonstrated satisfactory attention but seemed irritated. Gave relevant responses to questions.
4. Capacity to Read and Write**:** He is able to read and write with no difficulty
5. Abstract Thinking: Demonstrated ability to understand simple metaphors in English. Able to conduct simple mathematical calculations to determine his age and significant points in his life.
6. Memory**:** Mr. K's recent and remote memories were normal
7. Fund of information and knowledge: Consistent with his level of education, he has a bachelor's degree. Aware of social events. Able to participate in the interview appropriately. No signs of cognitive delay.

Mood and Affect

1. Mood: Sad and uneasy, concerned about challenging the order of protection.
2. Affect: Constricted but mostly expressionless
3. Appropriateness: Affect congruent with mood. Did not exhibit labile emotions, angry outbursts, or uncontrollable crying.

Motor

1. Speech: normal tone, speed, and volume
2. Eye contact: good eye contact with speaker
3. Body movements: No extremity tremors or facial tics. His body movements are normal given his age.

Reasoning and Control:

1. Impulse Control: Impulsive. Active suicidal ideation, described plan to jump from a building after discharge.
2. Judgement: Endorses no paranoia, bizarre delusions, auditory or visual hallucinations. Does not believe that he will face full consequences for what happened to his wife.
3. Insight: Is aware of his problems. Capable of relating those problems to himself. States that he needed to get his wife out of the way so he could jump.

Assessment:

Patient is a 65 y/o male with h/o major depressive disorder, compliant with his outpatient and inpatient medications, per patient he "needed to get" his wife "out of the way" so he could commit suicide by jumpig off his balcony. Patient had a recent suicide attempt 3 weeks prior to current admission at Elmhurst for which he was admitted to Mt Sinai but was subsequently discharged on cymbalta 40 mg daily, klonopin 0.25 mg daily, Naltrexone 50 mg daily, and Seroquel 50 mg nightly with outpatient follow up. TK endorsed increased stress with work as a CPA as a trigger for his behavior, and denied any marital issues. Patient does not have a long history of self harm, homicidal, or suicidal behavior. However he is currently actively suicidal with a plan. TK will benefit from admission to the inpatient psych unit on AB11, possibly pending arrest upon discharge. Consider giving ativan for increased anxiety.

DDx:

- Major Depressive Episode exacerbation (two recent suicide attempts, one act of extreme violence)
- Bipolar I onset (depressed mood, decreased interest in usual sources of enjoyment, decreased appetite, decreased need for sleep, feeling worthless, feeling hopeless, poor energy, poor concentration, feeling miserable increased problems at work)
- Adverse effect of a new psychiatric medications (cymbalta 40 mg daily, klonopin 0.25 mg daily, Naltrexone 50 mg daily, and Seroquel 50 mg nightly)
- Substance Abuse Mood disorder (previously an alcoholic however denies recent use)
- Narcissistic personality disorder (unable to empathize with actions taken, says his wife is a child and would not have been able to live without him)
- Malingering (in order to escape the consequences of his homicidal behavior)

Plan:

- Admit to AB11 (poor impulse control, active suicidal behavior, admits to having a plan, homicidal ideation,)
- CBC, CMP, POC Glucose HCG, Utox, Covid PCR, EKG reviewed → all WNL
- One to one observation every 15 minutes for active suicidal behavior

- Provide a safe and supportive environment; encourage participation in therapeutic group sessions, and activity sessions, and verbalize challenging thoughts & concerns.
- Stabilize and return to a new apartment or to police after discharge.

Progress note: After admission for 23 days, the patient remains depressed and suicidal with intent as well as a plan. No current signs of distress were observed. His mood is unseasy with constricted affect, Remains unconcerned about his near homicidal behavior. Sleeps 6-7.5 hours a night.Compliant with medication. Currently learned that the patient will be arrested on discharge, social work actively working with the patient's family to find him a new apartment. Patient may be a continuous threat to self and others. Patient would benefit from continued inpatient care. Patient was future-oriented in his thinking. He expressed wishes to appeal the orders of protection that his wife placed on him.

Justification for continued inpatient care: Patient remains suicidal with plan, is internally preoccupied with constricted affect. Patient is aware of his problems and is able to relate them to himself. He has history of one suicide attempt in the past month and half as well as one homicidal attempt in the past month which warrant admission at this time.

Plan:

- Will attempt to stabilize the patient and return to authorities after discharge.
- Provide individual/group therapy in a safe structured therapeutic environment
- Q 15 Min observation for safety
- PO Lorazepam 1 mg Q8hrs, daily for anxiety
- PO cymbalta DR capsule 40 mg daily for major depressive disorder
- Diphenhydramine 50mg PRN at night for sleep
- Naltrexone 50 mg PO daily for alcohol use disorder
- Quetiapine 200 mg PO nightly for major depressive disorder and suicidal ideation