Access to Electroconvulsive Therapy for an Adolescent Female with Treatment-Resistant Catatonia in a County Mental Health System

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INTRODUCTION

LAC+USC Medical Center serves over 10 million residents in Los Angeles County including children and adolescents seeking mental health services. With complex and lengthy legal procedures requiring judicial approval paired with limited insurance reimbursement, ECT services are a significantly limited treatment option for catatonia, especially for the pediatric population.

LEGAL DESIGNATIONS

5326.7 Subject to the provisions of subdivision (f) of Section 5325, convulsive treatment may be administered to an involuntary patient, including anyone under guardianship or conservatorship, only if:

(a) The attending or treatment physician enters adequate documentation in the patient's treatment record of the reasons for the procedure, that all reasonable treatment modalities have been carefully considered, and that the treatment is definitely indicated and is the least drastic alternative available for this patient at this time. Such statement in the treatment record shall be signed by the attending and treatment physician or physicians.

(b) A review of the patient's treatment record is conducted by a committee of two physicians, at least one of whom shall have personally examined the patient. One physician shall be appointed by the facility and one shall be appointed by the local mental health director. Both shall be either board-certified or board-eligible psychiatrists or board-certified or board-eligible neurologists. This review committee must unanimously agree with the treatment physician's determinations pursuant to subdivision (a). Such agreement shall be documented in the patient's treatment record and signed by both physicians.

(c) A responsible relative of the person's choosing and the person's guardian or conservator, if there is one, have been given the oral explanation by the attending physician as required by Section 5326. 2. Should the person desire not to inform a relative or should such chosen relative be unavailable, this requirement is dispensed with.

5326.8 Under no circumstances shall convulsive treatment be performed on a minor under 12 years of age. Persons 16 and 17 years of age shall personally have and exercise the rights under this article. Persons 12 years of age and over, and under 16, may be administered convulsive treatment only if all the other provisions of this law are complied with and in addition:

(a) It is an emergency situation and convulsive treatment is deemed a lifesaving treatment.

(b) This fact and the need for and appropriateness of the treatment are unanimously certified to by a review board of three board-eligible or board-certified child psychiatrists appointed by the local mental health director.

CASE

17 yo high-functioning female with a past psychiatric history of psychosis, depression, and 3 past psychiatric hospitalizations for psychosis was admitted involuntarily for danger to self and grave disability. Prior to admission, patient was maintaining a 4.0 GPA while leading an afterschool tutoring program for peers at her high school with plans on attending university to major in engineering until due to paranoia about being poisoned, she stopped taking her medications along with minimal eating a drinking due to fear of being poisoned. During the admission, the patient reported multiple delusions including Capgras, Cotard, erotomanic and ongoing paranoid delusions of 3 months duration that her food and medications contained poison. These delusions were in conjunction with a progressing disorganized thought process. An extensive medical workup consisting of imaging, serum and CSF labs along with Pediatric and Rheumatologic consults ruled out infectious, oncologic and autoimmune etiologies.

Initially, she was re-started on olanzapine to which she did not have a significant response at therapeutic dosing. Subsequently, she did not respond to trials of risperidone and aripiprazole which was followed by her condition progressing to a catatonic state where she averaged between a 28-32 score on the Busch-Francis Catatonia scale significant for mutism, catalepsy, mannerisms, negativism, ambitendency, and automatic obedience. IM lorazepam challenge was immediately initiated, showing a mild improvement in catatonia. Antipsychotic class of medications were discontinued due to concern for possible progression to neuroleptic malignant syndrome. Subsequently, lorazepam titration commenced over 2 weeks to a maximum of 24mg/day (PO) had no significant response. Carbamazepine trial was initiated while patient was concurrently on high dose lorazepam with no response followed by unsuccessful amantadine and clonazepam trials.

Parents' advocated for the patient to receive ECT after performing their own research, consulted with other psychiatrists and thorough discussion of risks, benefits and alternatives were discussed. Attempts to obtain admission for voluntary ECT with parents' consent at multiple facilities in Los Angeles County were denied due to her being a minor and pending court approval. After deciding to pursue ECT treatment, 1 month transpired until final court approval for a maximum total 9 sessions of ECT over a month.

DISCUSSION

I wish to illustrate the challenges that face children and adolescents with treatment-resistant catatonia along with their families who would benefit from emergent ECT treatment in Los Angeles County. Systems of care are particularly important in this case as the client had multiple agencies and systems involved in her care including the public defender, district attorney, public conservator, her parents, the treating psychiatrist and psychiatric team, multiple consulted psychiatrists, consulted medical teams, LA Department of Mental Health, LA Mental Health Court and Medi-Cal (Medicaid). All stakeholders involved play a different role in providing care, service and/or protection for the client with differing perspectives and responsibilities, but with the shared goal of beneficence for the client.

This client required documentation by 2 consulting child psychiatrists in addition to the primary treating psychiatrist and the local mental health director, filing for temporary conservatorship and consent by the public conservator, consent by her parents and final approval by the mental health court judge a process when expedited took 1 month. Mostly unique to the field of psychiatry and the treatment of ECT, where such extensive legal procedures are needed for emergent medical treatment.

As it currently functions, the overall mental health care within the County system often prolongs access to life-changing treatment.

REFERENCES

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