Lanarkshire Forensic Mental Health Service

DISCHARGE SUMMARY

Beckford Lodge
Caird Street
Hamilton
ML3 0AL
www.nhslanarkshire.co.uk

CONFIDENTIAL

Date Dictated: 14/06/2023
Date Typed: 19/06/2023
Our Ref: LS/AB/RW
CHI No: **2104673933**
Enquiries to: Medical Secretary
Direct Line: 01698 456215687552

Dear Dr Canning

Name: Andrew, Shaw
DoB: 21/04/1967
Address: Flat 1, 14 Hillhead Avenue, Glasgow, G73 4NJ

Date of Admission: 25th January 2021

Date of Discharge: 4th June 2023

Diagnosis:
Paranoid Schizophrenia
Complex PTSD

Medication on Discharge:
Paliperidone 150mgs monthly depot
Venlafaxine XL 225mgs daily
Aripiprazole 5mgs daily
Procyclidine 5mgs bd
Tamsulosin 400mcg once daily
Metformin MR 2mgs once daily
Atorvastatin 10mgs at night
Cholecalciferol 800 units once daily

Follow Up:
Mr Shaw will initially be follow up by the Forensic CMHT with a view to transfer to Eastvale CMHT following a period of stability.
RMO Dr Laura Steven
FCPN Maxine MacDougall

CPA arranged for 24/07/23 on teams (Mr Shaw not keen to attend)
Invites sent to Eastvale CMHT – Dr MacMillan (Consultant Psychiatrist) and Stuart Whyte (Team Leader)

History of Presenting Complaint:

Mr Shaw was admitted to Beckford Lodge on an Assessment Order on the 25th January 2021. He had been charged with four offences relating to the Road Traffic Act (1988), including one under Section 103 (1)(b) in that on the 3rd May 2019 on multiple roads in East Kilbride he did drive a motor vehicle while disqualified; one under Section 143 (1)(2) in that he did drive a motor vehicle as described previously without insurance; one under Section 163 (1)(3) he did fail to stop the motor vehicle when requested to do so by police and one under Section 2 he did drive dangerously.

He was initially remanded into custody but was later referred for admission to hospital by HMP Barlinnie in December 2020, as he was presenting as acutely distressed and suicidal. He had been experiencing auditory hallucinations in the internal and external space and believed that God had a purpose for him to face Lucifer when he was dead. He had no insight into these symptoms.

Personal & Background History:

Mr. Shaw was born in Bellshill but grew up in Hamilton. He lived with his Mother, Father and 3 elder siblings. His Mother worked as a cleaner and his father worked in the steel works. He was very close to his Mother before she died at the age of 45 years when he was 8 years old. His Father suffered from alcohol dependence and associated physical health complications. His Mother died when he was 8 years old and his recollection of this time is rather traumatic. His Father had been intoxicated with alcohol that night and a fight ensued between his parents. His Mother assaulted his Father with an ash tray and a physical altercation ensued ending in his Mother's death. He is unclear what her exact cause of death was. There appears to have been domestic violence between his parents especially under the influence of alcohol. His Father's alcohol dependence increased following his Mother's death and his ability to care for the children reduced. Mr. Shaw recalls having to fend for himself.

Mr. Shaw has 3 siblings. He was the youngest of 4 brothers with a significant age gap between him and his other Brother's (15, 17 and 18 years older). His Brothers are now all in the army. One of his Brother's returned to the family home when Mr. Shaw was aged 10 years and both physically and sexually abused him. Mr. Shaw stole his Brother's car and crashed it and thereafter was placed into Geilsland List D School due to concerns from Social Work about the home environment. It was in this environment that he learned to drive starting with tractors in the land there. This appears to have contributed to his drive and urge to be driving as this was a particularly stable period in his life, a feeling he is desperately seeking. He later transferred to Borstal before returning to live with his Father. His Brother was no longer living in the family home but his Father continued to suffer alcohol dependence and associated problems. Mr. Shaw reports that the Brother who abused him committed suicide approximately 10 years ago. His Father died of cancer 18 years ago and Mr. Shaw has struggled to settle anywhere since that time.

Mr. Shaw has spent a considerable amount of his adult life in prison mainly as a result of car offences. He can make some links between the traumatic events in his childhood and his driving offences. He describes how driving cars allows him to feel in control when in most of the rest of his life he does not feel in control. More recently he has reported that driving is the only time his hallucinations stop and he feels at peace. He perceives that people are untrustworthy and likely to either abuse him or abandon him. Although he has had relationships with women, these have largely been problematic due to his poor self-esteem and lack of ability to trust.

Education & Employment:

Mr Shaw attended mainstream schooling including Glenlee Primary School and Earnock High School. He was later cared for in a List D school where he found some stability and was well engaged in activities and groups there. He struggled academically and failed to achieve any qualifications. He has never managed to sustain any periods of employment. He tended to live and itinerant lifestyle between family and friends and has had multiple periods of incarceration.

Drugs & Alcohol History:

Mr Shaw has a long history of polysubstance misuse as a means to 'blocking out the voices'. He has used significant amounts of cocaine and street vallium in the past.

Past Psychiatric History:

Mr Shaw has had extensive contact with psychiatric services, both in Lanarkshire and in Glasgow. He had a prolonged admission to Hartwoodhill IPCU in 1997, the diagnosis at that time being of post traumatic phenomena secondary to multiple adverse childhood experiences and borderline personality disorder. In 2001 he took a significant overdose of Benzodiazepines and Ecstasy and required admission to hospital. On 31st October 2001 he presented as retarded, weepy, agitated and appeared suspicious and hallucinated. He complained of auditory and visual hallucinations and indicated that he could no longer cope. He was referred to Hairmyres Hospital for urgent assessment, but failed to attend. He presented again in June 2002 when he appeared quite paranoid, but did not comply with prescribed antipsychotic medication.

He had a brief admission between 11th May 2005 and 25th May 2005 to Gartnavel Royal Hospital. It was concluded that he was not suffering from on-going psychotic illness. He was facing serious charges at the time.

Over the years he has attracted different diagnoses at different times. However, the prevalent view in the past was that he suffers from Emotionally Unstable Personality Disorder and that at times he decompensates into psychotic illness. He has been treated with antipsychotic medication over the years, since 2006. This has been both in the form of oral medication and in the form of depot antipsychotic medication. His compliance with services has been variable. He tends to present in crisis and will accept medication. Although he often claims to get limited benefit from antipsychotic medication, the notes suggest that these do have a stabilising effect on him. His contact with services has also been disrupted by periods of incarceration.

He had a period of admission to Iona Ward, Low Secure Inpatient Unit, Beckford Lodge in February 2016 until May 2016. He was suffering from paranoid delusional beliefs including a

belief there was a microchip in his head controlling him, hallucinations of God and Prophets in both second and third person, formal thought disorder and struggled to function. He was treated with antipsychotic medication and discharged with follow up arranged in the community. He was incarcerated in August 2016 and released again January 2017 with a referral to the Forensic CMHT for follow up. He did engage reasonably well at that time. His care was transferred to East Kilbride Community Mental Health Services in February 2017 however he failed to attend and was essentially lost to follow up until 2020.

His most recent admission to psychiatric hospital prior to this one was from 25th August 2020 until 29th September 2020. He had been admitted to Queen Elizabeth Hospital and was referred to the liaison psychiatry service since he was openly responding to visual and auditory hallucinations. He admitted use of Cocaine and street Valium and was treated with Dihydrocodeine and Diazepam for withdrawal symptoms. The diagnosis on discharge was of trauma reaction secondary to psycho-social events and chronic substance misuse.

Progress on Ward:

On admission in January 2021 Mr Shaw presented as acutely and floridly psychotic. He was suffering from paranoid and persecutory ideation, was very withdrawn and disengaged with poor self-care and self-neglect. Hallucinations were present in several modalities, including auditory, visual, olfactory and tactile. He also described symptoms of thought blocking and thought insertion as well as passivity of thoughts feeling his thoughts were being controlled by others but was unsure who was responsible. He also reported ideas of reference from the television and radio and struggled to watch or listen to these even as his symptoms improved as he described a need to listen to the voices or else they get louder and angrier. Mr Shaw also suffered from trauma symptoms with flashbacks, nightmares and associated anxiety and panic. He was treated with Risperidone initially and there was some improvement over a number of weeks, however, there were residual psychotic symptoms remaining and it was not clear if Risperidone alone was going to be effective. He was granted sometime out of the ward to go to the local shops, however unfortunately on the 29th June 2021 Mr Shaw absconded and failed to return from this time out. At this time, we learned that he had purchased a car online and drove this despite not having a valid driving licence or insurance, therefore accruing further police charges. He was returned to the ward on the 8th July 2021. Unfortunately, once he returned to the ward he was once again floridly psychotic with significant distressing symptoms having not had access to any medication over the week he had absconded. He reported an urge to drive as this is the only time he is not hallucinated and felt distressed at the commands from the voices. He stated that he feels “at peace” when driving cars but the voices return immediately when he stops.

Following his return to the ward it was decided that Mr Shaw have a trial of Clozapine, however, he did not respond well to this even at the lowest doses with physical complications such as significant over sedation and autonomic depression. This was thought to be perhaps due to his morbid obesity in combination with over-sedation leading to respiratory depression. It was not considered safe to continue on clozapine and this was discontinued. He was once again started on Risperidone and this is now administered as a depot intramuscular injection namely Paliperidone. This was further supplemented by oral antipsychotics in addition, such as some regular Aripiprazole and as required Haloperidol due to ongoing residual symptoms which sounded psychotic in nature and that were causing him great distress.

Although Mr Shaw did not feel that he had improved at all, we did note that his mental state was getting better. He intermittently continued to self-isolate in his room and complain of continued auditory and visual hallucinations, however, he gradually began to interact well with staff and peers and became more evident around the ward. At these times he was more reactive in mood and affect. He does continue to complain about symptoms and reports little to no improvement, however objectively this is not the case. He has been trialled on multiple different combinations of medication to find the best combination to treat his paranoid schizophrenia, complex PTSD and anxiety. Given he reported little benefit from Venlafaxine in managing his anxiety symptoms this was reduced and stopped but quickly led to a relapse in low mood, withdrawal, increased hallucinations and increased anxiety. This was re-started with a clear improvement in his presentation over several weeks. Unfortunately, Mr Shaw tends to be destabilised by any stressors and will experience an increase in hallucinatory experiences leading to periods of withdrawal and complaints of poor sleep requiring PRN medication to ease the agitation.

In terms of psychological work, Mr Shaw has engaged quite well and has undergoing extensive safety and stabilisation work, giving him coping skills and strategies allowing him to progress to CBT for psychosis and then trauma focused therapy. He still needed significant encouragement to use his time out of the ward often preferring to self-isolate and reporting he struggled in busy environments due to lots of voices mixing with his own voices making it more difficult for him to hear his own voices leading to distress. There does seem to be a degree of reliance on being able to hear his voices and he has stated he would not likely like it if his voices disappeared entirely. As a result of this Mr Shaw was at points reluctant to engage with OT work to facilitate discharge and indeed became very anxious at points when progress was being made. He had been reluctant to go home on pass for long periods of time and openly voiced a desire to remain in the ward longer. He required maximal reassurance and firm boundary setting in order to progress his transition back to community living. He did successfully manage consecutive overnights prior to discharge for up to 5 days at a time. It was clear Mr Shaw is invested in the patient role and needs to feel secure to contain himself.

Mr Shaw was discharged on the 12th June 2023. He continues to have some issues with residual and breakthrough symptoms related to stress, however he has remained mentally stable and at his baseline. He will initially be follow up by the Forensic Community Mental Health Team

If there are any queries, please let us know.

Yours sincerely,

Authorised on 10/07/2023 18:22:33 by Laura Steven.

Dr Laura Steven
Consultant Forensic Psychiatrist

cc Maxine MacDougall, FCPN, Caird House
cc Dr Graham MacMillan, Consultant Psychiatrist, Eastvale CMHT