Lanarkshire Forensic Mental Health Service

GIGHA WARD / IONA WARD
BECKFORD LODGE
CAIRD STREET
HAMILTON
ML3 0AL

Date:	1st May 2023
Our Ref:	LS/CB
CHI No:	2104673933
Enquiries to:	Admin. Staff
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Stuart Whyte
Team Leader
Eastvale Resource Centre
130 Stonelaw Road
Rutherglen
GLASGOW
G73 2PQ

Dear Colleague

ANDREW SHAW, CURRENTLY C/O IONA WARD, BECKFORD LODGE, HAMILTON
ADDRESS: 14 HILLHEAD AVENUE, RUTHERGLEN, G73 4NJ
DOB: 21/04/67

I write to refer the above named patient for consideration for follow up in the community under the care of Eastvale Resource Centre. Mr Shaw is a 56-year-old man who is currently an in-patient in Iona Ward (Low Secure), Beckford Lodge who is receiving treatment for Paranoid Schizophrenia and Complex PTSD. He is currently on a Compulsion Order and is currently transitioning into a new tenancy in the Rutherglen area.

BACKGROUND:

Mr Shaw was referred for admission by HMP Barlinnie in December 2020 presenting as acutely distressed and suicidal. He had been experiencing auditory hallucinations in internal and external space. He believed that God had a purpose for him to face Lucifer when he was dead. He had no insight into these symptoms. He was transferred to Iona Ward in January 2021 where he has remained since.

Mr Shaw was charged with various offences under the Road Traffic Act 1988, Criminal Justice and Licensing (Scotland) Act 2010 and Vehicle Excise and Registration Act 1994, including; theft of a vehicle, driving without insurance, fraudulent alteration of a vehicle number plate, dangerous driving, failure to stop and assault to

endangerment to life. Mr Shaw was remanded in HMP Barlinnie on 23rd November 2020. Mr Shaw's forensic history of offending relates to motor vehicle crime and associated offences, often of fraudulent activity. There has been some perpetration of violence while driving erratically to evade police and he also has two historical charges of assault including severe injury and permanent disfigurement.

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 ashtray 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 on 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 Valium in the past. There have not been any issues with drug use during time out the ward during this admission.

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 anti-psychotic medication.

He had a brief admission between 11th May 2005 and 25th May 2005 to Gartnaval 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 anti-psychotic medication over the years, since 2006. This has been both in the form of oral medication and depot antipsychotic medication. His compliance with services has been variable although if a good rapport is established he seems to engage better. He has struggled with the "abandonment" of changing consultants or staff leaving a service in the past having grown attached to the care giver. He tends to present in crisis and will accept medication. Although he often claims to get limited benefit from anti-psychotic 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.

He has accrued over 50 police charges for numerous offences including assault and assault with severe disfigurement. However, the vast majority of his offences related to road traffic offences. Whilst incarcerated in HMP Barlinnie he displayed symptoms suggestive of a psychotic illness including: hallucinatory experiences including auditory in the third person, tactile and visual; paranoid, suspicious and religious delusional beliefs; emotional withdrawal; and lability of mood. He was admitted to Iona Ward, Beckford Lodge on 25/01/2021 on Section 52D of the Criminal Procedure (Scotland) Act 1995 (Assessment Order). This was later converted to Section 52M of the Criminal Procedure (Scotland) Act 1995 (Treatment Order) and more recently a Compulsion Order.

PROGRESS ON THE WARD:

On admission in January 2021 Mr Shaw continued to present as acutely and floridly psychotic. He was suffering from paranoid and persecutory delusional ideation, was very withdrawn and disengaged, not self-caring and neglecting his own health. He struggled with hallucinations in several modalities including auditory, visual, olfactory and tactile. He suffered thought blocking and thought insertion and as his mental state has improved he has been able to report passivity of thoughts feeling an external source is trying to control his thoughts. He gets ideas of reference from the TV and radio. He has significantly decompensated in terms of his trauma symptoms with flashbacks, nightmares and associated anxiety and panic. He was treated initially with an oral antipsychotic, namely Risperidone, which over a number of weeks did have some effect and saw him more alert and able to come out his room and socialise around the ward. He was evidently less hallucinated although the residual psychotic symptoms were evident with continued hallucinations. As his mental state improved he was granted some time out with the ward to the local shops. Unfortunately, on 29/06/2021 Mr Shaw absconded and failed to return from this time out. It was our understanding he had purchased a car online and drove this despite not having a driving license or insurance and accrued further police charges. He was absent from the ward until 08/07/2021 and did not take any medication during this time. Unfortunately, on his return he was once again floridly psychotic with significant distressing symptoms. He reported that he has an urge to drive as this is the only time he is not hallucinated and distressed. He feels ‘at peace’ when driving cars.

Following his return to the ward we attempted to treat him with a stronger antipsychotic, namely clozapine however unfortunately he did not respond well to this with physical complications including significant over-sedation and autonomic depression. He has since been re-started on the antipsychotic risperidone given this has worked for him in the past and this is now administered as a depot intramuscular injection, Paliperidone. We further supplemented this for a while with additional oral antipsychotics namely haloperidol because he continued to complain of distressing symptoms which sounded psychotic in nature.

We noted that his mental state did improve over time despite his continued denial of any improvement. He did intermittently continue to self-isolate in his room, complain of continued auditory and visual hallucinations and paranoid thoughts. He gradually began to interact more with staff and peers and was more evident around the ward. He was noted to be reactive in mood and affect at these times. Subjectively, he has continued to complain of symptoms and reports little to no improvement however we have objectively observed significant improvement. We have trialled numerous different combinations of medication to find the best combination to treat his Paranoid Schizophrenia, complex PTSD and anxiety. He has a significant history of trauma and appears troubled by this on a daily basis. Any stressors tend to destabilize him and he experiences an increase in hallucinatory experiences and has poor sleep often seeking PRN. He will self-isolate at these times.

Mr Shaw engaged reasonably well with psychology throughout his time in hospital. He has undergone extensive safety and stabilization work to provide him with the coping skills and strategies needed before progressing on to do more trauma focused therapy that had a particular focus on CBT for psychosis. He needed significant encouragement to use his time out the ward and even still opts to remain in the ward unless there is a purpose to going out. We recognize he enjoys "the patient role" and seeks to remain in the security and comfort of the hospital. However, we have had to progress his time out the ward with significant encouragement. He has delayed as best he can any progress in his tenancy to make it suitable for overnights. He may be institutionalized to a degree given the lengthy admission. Despite this, he has remained mentally stable and at his baseline. He will continue to have episodes of "breakthrough" pseudo-hallucinations and this appears more often than not to be linked to stress.

MEDICATIONS:

Venlafaxine XL 225mg mane
Paliperidone 150mg monthly
Aripiprazole 5mg mane

MENTAL STATE EXAMINATION:

At assessment, Mr. Shaw was casually dressed and moderately well kempt. He made reasonable eye contact and did not appear to be openly responding to visual hallucination. He was alert and orientated to time, place and person. His speech was quiet and he was limited in his answers however when pushed he will respond in sentences. He demonstrates a lack of motivation and energy which can appear at times to be negative symptoms. He gets fleeting suicidal thoughts but denied any intent to act on these. He enjoys the noise of the road and the cars as a tool to self-soothe.

He described his mood as "alright" and rated it as 5 out of 10. Objectively he appeared low with a blunted affect. He stated his sleep is variable day to day and he spends a lot of time asleep during the day. He stated he likes to lie in the dark with his eyes shut to minimise the hallucinations. He stated he has a variable appetite and will tend to try and avoid eating at meal times. He does enjoy snacking, especially overnight.

He has a tendency to have vague paranoid ideation and worries about "people" knowing his whereabouts. We do consider that Mr Shaw has had antisocial acquaintances in the past and that this is somewhat based in reality. There has not been any passivity for some time, no thought blocking and no ideas of reference from the TV. He does continue to suffer "voices" and we believe the residual voices and pseudo-hallucinations and are responsive to stress. His insight has improved regarding his diagnosis and he is accepting of care and treatment offered. He is willing to trial different combinations of medications to find what gives the best relief from his hallucinations.

SUMMARY:

Mr Shaw is a 56-year-old male who has a diagnosis of paranoid schizophrenia and complex PTSD. He was admitted from prison to Iona Low Secure Unit in January 2020 where he has remained since. He is now as mentally stable as he can be, although struggles with fluctuations in mood and pseudo-hallucinations in response to stressors. He is prescribed a depot antipsychotic and an antidepressant for generalised anxiety. He is now in the process of transitioning back to community living once again. He feels secure in 'the patient role' and can be resistant to

attempts to rehabilitate him but we have now made some good progress. He has been allocated a tenancy in Rutherglen and is engaged with our OT. He does not have any care support needs as such but does require some encouragement and perhaps support with structure and routine. His MHO has intentions of continuing to review his situation as he transitions and seek the appropriate support if needed perhaps from charity organisations. He has a long history of offending in relation to fraudulently obtaining or theft of motor vehicles and road traffic offences for not stopping when asked to do so by police. This links somewhat to his traumatic past and he recognises that driving a car very fast has previously been one of his main coping strategies and further offending remains a risk going forward. He appears motivated to avoid this and uses the sound of cars and the road to soothe himself. I would expect he will require medical and nursing input in the first instance but may also benefit from OT and psychology if you deem this necessary.

We would be grateful for your consideration of following Mr Shaw up on discharge. We have a discharge CPA planned for 10/05/23 at 3pm face to face in Beckford Lodge but may be able to accommodate remotely if necessary. His estimated discharge date in 12/06/23. We would hope you would be able to attend the CPA so we can share our formulation with you and have you meet Mr Shaw.

If you have any further questions, please do not hesitate to contact me.

Yours sincerely

Dr Laura Steven
Consultant Forensic Psychiatrist