NHS Lothian

Cambridge Street House
5/7 Cambridge Street
Edinburgh
EH1 2DY

Adult Mental Health SW OPD

Dr Murray
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 27/01/2025

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (67 years) 600086642R
Attendance Date	24/01/2025		
Consultant	Dr Deborah J Cooper		

Dear Dr Murray

I had a telephone appointment with Mr McRobb on 24/1/25. He had requested it to be in this manner, rather than in person.

Things are unchanged over the last few years. An agoraphobic picture is his main challenge. He struggles to leave his home beyond taking the rubbish out and will use taxis for appointments he sees as absolutely essential, for example the dentist for toothache. He is drinking less alcohol now, well within recommended limits, which is positive. He feels he is eating less but has not lost any weight which he attributes to Mirtazapine. Sleep is variable, but there are some nights it is reasonable. There is no current psychosis but he remains quite hypervigilant and worries about being harmed if he leaves his flat. This is easily challenged and he accepts it is not a likely proposition.

Ronnie does not want to consider non-pharmacological options to challenge his anxiety. He does want to try and push himself a little more, in his own gradual timing, to try and get out a little more and is going to try and do this moving forward. He does not want to change medication and denies side-effects other than the weight gain. Given the stability in his presentation, albeit his significant anxiety has continued, and lack of change to his treatment, I am going to discharge him presently. Mr McRobb was in agreement with this. Do feel free to refer him back to services should things deteriorate.

Yours sincerely,

Electronically checked by Dr. Cooper

Dr. Deborah Cooper
Consultant Psychiatrist

NHS Lothian

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EH1 2DY

Adult Mental Health SW OPD

Dr Murray
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 12/11/2024

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (66 years) 600086642R
Attendance Date	03/05/2024		
Consultant	Dr Deborah J Cooper		

Dear Dr Murray

Unfortunately, Mr McRobb cancelled his appointment with me on 08/11/2024. I will send him another.

Yours sincerely,

Electronically checked by Dr. Cooper

Dr. Deborah Cooper
Consultant Psychiatrist

NHS Lothian

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5/7 Cambridge Street
Edinburgh
EH1 2DY

Adult Mental Health SW OPD

Dr Murray
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 10/05/2024

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (66 years) 600086642R
Attendance Date	03/05/2024		
Consultant	Dr Deborah J Cooper		

Dear Dr Murray

Diagnosis:
1. Organic psychosis
2. Agoraphobia/anxiety

Medication:
1. Fluoxetine 40mg
2. Aripiprazole 20mg
3. Mirtazapine 15mg
4. Vitamin D

I met with Ronnie on 3 May. He presents as he usually does albeit it was the first time I had seen him in person for quite some time. He lives quite a restricted lifestyle, staying in the home, as the prospect out is too anxiety provoking. At times he will worry that noise from the neighbour's flat is about him but was not clearly meeting the threshold of psychosis today. He retains reactivity of his affect and there were no acute risks today. His sleep is poor and he would like to try Melatonin again which I think is reasonable. I would be grateful if this could commence at 2mg nocte and can increase to 4mg if needed.

I will offer him one further appointment but if things remain static with regards to medication he is aware that I will discharge him at that point in time.

Yours sincerely

E-checked by Dr. Cooper

Dr Deborah Cooper

Consultant Psychiatrist
dc/mo

NHS Lothian

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5/7 Cambridge Street
Edinburgh
EH1 2DY

Adult Mental Health SW OPD

Dr Murray
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 08/08/2023

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (65 years) 600086642R
Attendance Date	28/07/2023		
Consultant	Dr Deborah J Cooper		

Dear Dr Murray

Diagnosis:
1.Previous organic psychosis
2.Chronic generalised anxiety disorder with agoraphobia

Medication:
Aripiprazole 20mg
Fluoxetine 20mg
Mirtazapine 15mg

I had a phone consultation with Ronnie on the 28th of July. I had to move the time of the appointment and he reported he was unable to attend in person as a consequence. He very seldomly leaves the house due to feelings of anxiety. Although he is unhappy at being 'a prisoner in my own home' he is reluctant to embark on treatment that would help him tackle this such as graded exposure. Given his lack of exposure to sunlight I did wonder whether he would benefit from vitamin D. He complains of chronic lethargy. I have explained to Ronnie that his medication has been broadly unchanged for some time now and, if we are making no changes, and indeed if he is not embarking on further treatment, I would probably discharge him back to your care. He will give this some thought between now and our next appointment.

Plan:

1. I would be grateful if he could have a trial of a vitamin D with this added into his blister pack.
2. I will review him in around 9 months.

Yours sincerely,

Electronically checked by Dr Cooper

Dr Deborah Cooper
Consultant Psychiatrist in Adult Psychiatry

DC/JC

NHS Lothian

Cambridge Street House
5/7 Cambridge Street
Edinburgh
EH1 2DY

Adult Mental Health SW OPD

Dr Murray
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 14/03/2023

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (65 years) 600086642R
Attendance Date	20/01/2023		
Consultant	Dr Deborah J Cooper		

Dear Dr Murray

Diagnosis:
1. Previous organic psychosis

Medication:
1. Aripiprazole 20mg
2. Fluoxetine 20mg
3. Mirtazapine 15mg

I had a phone consultation with Ronnie on the 20th of January. He cancelled our face to face appointment as he was waiting on a cooker delivery. He reports that things have been fairly consistent with him struggling to leave his home due to anxiety and he links this back to trauma experienced during his time in the Army. He stopped all his medication abruptly at the end of last year; he was worried about weight gain and reported that he was "psychotic" for a few days. He felt as though he was in an alternate reality and a number of his traumatic memories came back to him. I do not think he was assessed during that period. It has helped him realise that his medication is more helpful than he thought and is therefore happy to continue it.

He was complaining of fatigue, polyuria and a sensation of incomplete bladder emptying and I suggested he discuss this with you.

I will organise to see him in six months.

Yours sincerely

Electronically checked by Dr Cooper

Dr Deborah Cooper

Consultant Psychiatrist
dc/mo

NHS Lothian

Cambridge Street House
5/7 Cambridge Street
Edinburgh
EH1 2DY

Adult Mental Health SW OPD

Dr Murray
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 24/10/2022

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (64 years) 600086642R
Attendance Date	23/09/2022		
Consultant	Dr Deborah J Cooper		

Dear Dr Murray

Unfortunately Mr McRobb did not attend his appointment with me on the 23rd September 2022. This follows a series of missed appointments and I am therefore discharging him at the current time.

Yours sincerely

electronically checked by Dr Cooper

Dr Deborah Cooper
Consultant Psychiatrist

NHS Lothian

Cambridge Street House
5/7 Cambridge Street
Edinburgh
EH1 2DY

Adult Mental Health SW OPD

Dr Murray
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 03/11/2021

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (63 years) 600086642R
Attendance Date	15/10/2021		
Consultant	Dr Deborah J Cooper		

Dear Dr Murray

Unfortunately Mr McRobb cancelled his face to face appointment, requesting a phone appointment. However, I was not able to reach him on the telephone at the time of the appointment. I will send him out another appointment.

Yours sincerely

Electronically checked by Dr Cooper

Dr Deborah Cooper
Consultant Psychiatrist
dc/mo

NHS Lothian

Cambridge Street House
5/7 Cambridge Street
Edinburgh
EH1 2DY

Adult Mental Health SW OPD

Dr Murray
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 22/06/2021

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (63 years) 600086642R
Attendance Date	09/06/2021		
Consultant	Dr Deborah J Cooper		

Dear Dr Murray

Re: Ronald McRobb / CHI 3012571450

Unfortunately Ronnie did not attend his appointment at Cambridge Street House on the 9th June. I will send out a further appointment on a routine basis.

Yours sincerely

Dr Deborah Cooper MB ChB MRCPsych Approved Medical Practitioner
Consultant Psychiatrist

NHS Lothian

Mental Health Services

Adult Mental Health SW CMHT

Dr Murray
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 01/02/2021

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (63 years) 600086642R
Attendance Date	26/11/2020		
Consultant	Tracey x Johnstone		

Dear Dr Murray

I am writing to advise of the discharge of Mr Ronald McRobb from the Community Mental Health Team. He will continue to be reviewed by Dr Cooper in her outpatient clinic.He has also been placed on our Fast Track system should he require psychiatry input in the next two years, he will not need a new referral.

Mr McRobb, or Ronnie as he likes to be known, was referred to the community mental health team from Dr Cooper in June 2018. There had been a few concerns raised about Ronnie's mental state, in particular paranoia regarding people coming into his flat to harm him. Ronnie had reportedly barricaded himself intohis bathroom for days, armed with a knife for protection. Due to reluctance for him to leave his flat, it was agreed longer, more regular assessment was required to try to review the situation.

Ronnie engaged with the CMHT on a two week basis and all of his appointments where at his home. Ronnie presented as a polite and pleasant older man who was a bit lonely. His accounts of his mental state were all after the fact with variable intensity. There was neverany objective evidence of psychosis on review however his accounts would report such. He never contacted CambridgeStreet outwith appointments making assessment of psychotic symptoms difficult.

Ronnie's presentation appeared more of low mood and anxiety. Ronnie was offered a range of therpuetic therapies - anxiety management, graded exposure with a support worker anda referral to psychology for cognitive behavioural therapy. However, Ronnie declined all of these, saying "they don't work" and opting for medicinal solutions instead. It was repeatedly advised to Ronnie that medication alone is not going to change things howeverhe remained firm he did not wish to engage with this work.

Ronnie found a range of medications intolerable due to side effects and he was tried with various antipsychotic medications and anti depressants. This became the main topic of the appointments and Ronnie's reluctance to tryother suggestions. Ronnie became quite dependant on our engagements, enjoying the company but not making much progress in his recovery. Unfortunately, late 2019, Ronnie waspicked up by the police after going to his neighbours flat with a knife. He was subsequently admitted to the Royal Edinburgh Hospital for further assessment.

During this admission, it appeared that Ronnie did indeed experience psychotic symptoms and was noted to be very paranoid and suspicious early into the admission. He was stabilised on effective treatment and discharged back to CMHT. It remains unclear what exactly triggered this episode of illness however there is a suggestion that reintroduction ofSertralinemaybe the cause. This is the second significant psychotic relapse Ronnie has had when Sertraline has been increased. This should be used with caution if ever considered for Ronnie in the future.

Following discharge from the REH, Ronnie appeared to go back to his baseline mental state. Ronnie continued to decline further input or support other than what he has currently. Following discussion with Dr Cooper, it was agreed that while Ronnie is declining further input, there is no longer a role for the CMHT at this time. Ronnie found this very difficult to hear and continually referred to "being dumped". Ronnie again was offered psychological input to which he declined. We discussed Fast Track and he engaged minimally in a Staying Well Plan.

Ronnie would benefit from longer term social support to get him out of his flat and integrate into the community. He would also benefit from some cognitive behavioral therapy/anxiety managementto help manage his anxiety symptoms rather than medication. Any futureinput from servicesshould betime limitedand discussed at the beginningwith Ronnie as he struggled with the disengagement andvoiced that he felt abandoned by services.

Please do not hesitate to contact Cambridge Street House if you have any concerns. Dr Cooper will send him an outpatient appointment in due course.

STAYING WELL PLAN

Surname: McRobb
First names: Ronnie
DOB:
CHI:
or affix patient ID label

Date of Plan:

Team / service: SW CMHT

Signs that I am feeling well (how I feel, things I do etc)

Watching television

Reading

Going to the gym

Things that help me stay well

Positive thoughts

My strengths / what I am good at

Keeping things in order

Good listener

Follow advice

Good cook

Manage finances

Good DIY skills

Contacting relevant services

Triggers or things that can make me feel unwell Unhappy thoughts
Early signs that I may be becoming unwell Voices inside/outside my head
Things that I can do that help **1**. Distraction/watch TV/listen to music
2. Anxiety management technuiques
3. Phone Cambridge Street/hospital

Things that other people can do to help me	
Who can help	**What they can do**
Daughter Son	Talk on the phone or text

Crisis signs

Voices

Hallucinations

Disengagment from services ie nurse/GP

Things I can do that help if in a crisis

1. Try to reach out/make contact with somone

2. Phone nurse/hospital

3.

Things that other people can do that help me in a crisis

Who can help	**What they can do**
Son Daughter	Talk to me on the phone

Key Contacts

	Name	Number	Hours of contact
Key worker	Cambridge Street House	0131 537 8650 0131 286 8108	Mon-Fri (9am -5pm) Sat/Sun/PH (8am-4pm)
Mental Health team	Mental health assessment service	0131 537 6000	Out of hours number
GP	Springwell medical practice	0131 347 1860	Mon-Fri (9am-5pm)
NHS 24		111	24 hours

Is it okay to send a copy of your staying well plan to your friend/carer? **If so provide name and contact details:**	Yes ☐ No ☒

	Name	Signature	Date
Service user	Ronnie McRobb		
Keyworker	Tracey Johnstone		
Consultant	Dr Cooper		

Surname:**McRobb**
First name:**Ronald**
DOB:**30/12/57**
CHI:**3012571450**
or affix patient ID label

RISK ASSESSMENT LVL 1

Team SW CMHT

Date: 01/02/21

Time: 1130

RISK FACTORS Identify all from Risk Factor List including	**Historical factors** **Illness factors** **Contextual factors e.g. housing, relationships, loss of role, physical illness**

RISK TO SELF

Yes ☐ No ☐ Not Known ☒

Previous self harm/suicide attempts, family history of suicide, socially isolated, planning suicide, access to lethal method, hopelessness

No DSH/suicdal thoughts or acts documented.
Historical excessive alcohol abuse since the early 90's.
Cannabis use as a teenager.
Long standing anxiety and depression, tried on various antidepressants with little effect.
2015-first reported psychotic episode-hearing voices
2017- developed cellulitis and belived kids had been injecting him with keotone every night-called the police-breif intervention from IHTT. Quick resolve with some Olanzapine.
2018 to current -further psychotic episode reported, visual hallucinations of people outside his flat conspiring to kill him and his family. Barricaded self into bathroom armed with a knife. Believes neighbours are talking about him, planning to harm him. Says he has chased "someone" with a pole into the garden.

RISK TO OTHERS

Yes ☒ No ☐ Not Known ☐

Previous violent acts, use of / access to weapons, previous admission to secure unit, intoxicated; convictions for violence, supervision failure, known fire risk

None documented.
Previously in the army for 10 years, served during Irish conflicts.

RISK FROM OTHERS

Yes ☐ No ☒ Not Known ☐

Abuse, exploitation, domestic violence, neglect

RISK TO CHILD(REN)

Yes ☐ No ☒ Not Known ☐

Neglect, abuse, child included in suicide plans, delusional thinking

A consultant psychiatrist should be directly involved in all clinical decision making for those who may pose a risk to children

RISK OF SELF NEGLECT

Yes ☒ No ☐ Not Known ☐

Health, memory, cognitive impairment, physical impairment

Possible due to excessive alcohol abuse in the past. Can be quite repetative in recalling events/happenings.

RISKS RELEVANT TO SERVICE PROVIDERS Yes ☒ No ☐ Not Known ☐

e.g. risks to staff, circumstantial or environmental risks identified for visiting staff

Poor attendance for appointments.
Does not want psychological input. Has been offered CBT in the past, DNA.
High benzodiazepine dependance and seeking medicinal answers rather than psychological.

CARER'S VIEW OF RISK

LEVEL 1 RISK STATEMENT

What are the main risks; who are they to; how severe are they; what makes the risk worse; what protects against the risk

Ronnie presents as low risk currently.

Ronnie is has not harmed himself or others but becomes increasingly paranoid that people are out to get him and arms himself with weapons. Sleep is a big factor in the worsening of symptoms.

Ronnie is chronically anxious and depressed and has ben for a long time. He has sought help when things get bad for him, either police, his daughter or GP. His episodes do resolve and he is able to rationlise his thoughts and identify them as delusional/paranoid.

Ronnie has good insight and would do well if he felt in a position to engage in psychological work.

Safety / Risk Management Plan

Include plan if risks not known/further information needed

Complete staying well plan.

Ongoing suggestion of psychological work.

Avoid benzodiazepines where possible.

Encourage natural sleep hygiene.

Sources of information used: Tick if mental health record not available ☐				
Mental Health Record ☒ Vols:	TRAK ☒	Service User ☒	Family / Carer ☐	Others ☐ Specify:
Assessment discussed / shared with: Family / Carer ☐ Admitting doctor ☐ Ward Consultant ☐				

Community Consultant ☒ CPN/OT ☐ Social Worker ☐ Other ☐ Specify:				
Level 2 Risk Assessment indicated?	Yes ☐	No ☒	**Responsible team:**	

Designation	Name	Signature	Designation
Completed By	Tracey Johnstone		
Consultant	Dr D Cooper		Consultant

Review	**Date**
Change to Risk Factors?	
Change to Plan	

Designation	Name	Signature	Designation
Completed By			

Review	**Date**
Change to Risk Factors?	
Change to Plan	

Designation	Name	Signature	Designation
Completed By			

Review	**Date**
Change to Risk Factors?	

Change to Plan

Designation	Name	Signature	Designation
Completed By			

Suicide/Self-Harm	Violence	Other Risk Factors
HISTORICAL and SITUATIONAL FACTORS		
1. Previous self-harm Includes self harm coming to medical attention and actual suicide attempts.	**1. Previous violent acts** Serious or planned acts, that maybe came to others' (eg police, carers, medical) attention.	**1. Vulnerable due to learning disability** Not LD per se, but LD leading to potential risk to self
2. Use of violent methods	**2. Use of weapons**	**2. History of exploiting others**
3. Mental illness diagnosed	**3. Previous admission to secure units**	**3. History of being exploited**
4. Socially isolated	**4. Convictions for violence / assault** Includes homicide, attempted murder, bodily harm, common assault but not always breach of peace	**4. Previous history of falls**
5. Past diagnosis of personality disorder, or known impulsivity	**5. Past diagnosis personality disorder; psychopathy; known impulsivity** Psychopathy is classically characterised by impulsivity, callousness, criminal versatility, and a lack of remorse or empathy	**5. History of self-neglect or neglect of others** – children or other dependents This might be deliberate, or as a result of disability.
6. Major physical illness	**6. Alcohol or drug misuse**	**6. Lacks basic housing amenities** Water / heat / light. Is the absence of amenities beyond the individual's control?
7. Alcohol/drug misuse may require third party history to establish. What was purpose, and effect on behaviour of substance use?	**7. Male under 35**	**7. Previous known fire risk** Inadvertent or deliberate.
8. Family history of suicide	**8. Prior supervision failure** Major failures in parole, probation, or MHA compliance. Also, absconcion risk	**8. Socially or culturally isolated**
SHORT-TERM OR PRECIPITATING FACTORS		
9. History of treatment non-adherence	**9. History of treatment non-adherence**	**9. Eating disorder**
10. Planning suicide how detailed are the plans? Serious intent? Are there precautions against detection, and final goodbyes?	**10. Intoxicated** With drink or drugs at the time of assessment	**10. Difficulty communicating views** Speech or cognitive impairment, or cultural / language difficulties
11. Access to lethal method	**11. Acute positive psychosis** Includes destructive command hallucinations, referential paranoid delusions, and passivity phenomena	**11. Comprehension difficulties** Fluctuating level of consciousness, or delirium, as well as other cognitive impairment.

12. Hopeless / helpless Could be a manifestation of underlying low mood. Feels trapped or describes external locus of control?	**12. Violent fantasies**	**12. Confusion or disorientation**
13. Recent major loss Significant recent (< 1 month) life event, maybe with accompanying behavioural change.	**13. Identified target**	**13. Sexually disinhibited or aggressive** This must be directly witnessed, and be more than inappropriate comment.
14. Recent psych in-patient discharge Recent = <1 month, from acute psychiatric inpatient unit, whether planned or not	**14. Access to weapons** This may indicate the degree of planning	**14. Significant financial problems** It may not be the total debt value, but the impact of the debt that matters
15. Current / recent treatment non-adherence	**15. Current / recent treatment non-adherence**	**15. Current self-neglect**
PROTECTIVE FACTORS		
16. Willing to respond to advice/carers	**16. Willing to respond to advice**	**16. Willing to respond to advice/carers**
17. Has close relationship Is there someone (or a pet) who needs them or loves them?	**17. Availability of appropriate services** May be correctional or medical / rehabilitative.	**17. Availability of appropriate services** Medical, rehabilitative, or social services.
18. Religious beliefs Catholic and Jewish faiths said to be particularly protective.		

Surname: McRobb
First name: Ronald
DOB: 30/12/57
or affix patient ID label

MENTAL HEALTH
SINGLE ASSESSMENT

CHI: 3012571450

NHS Lothian

Date: 29/6/18
Time:1100

1. Alerts (e.g. Allergies, safety issues)

None reported

2. Diagnosis/ICD 10 (if known)	Psychosis Not Otherwise Specified	
3. Legal status	MHA Section Inf	Expiry date

4. History Of Presenting Complaint

Person's view of current situation inc usual ways of coping:

Looking for support.

Reports long history of depression and anxiety, describing regular panic attacks. Believes to have a social phobia and does not like being around crowds.

Has contact with Veterans First Point on a Tuesday afternoon and a "Tools for Life" group on a Tuesday morning run by SAMH.

Hardly sees his family, all live in West Lothian. Occassionally sees 1 son.

Recently Ronnie reports psychotic symptoms. He says he doesn't leave the house and believes people are out to gt him. During these times does not eat, drink or sleep because he is paralysed with fear and remains in one room. This has happened a few times in a week prior to starting the new medication.

Ronnie says he hears voices of people he recognises talking about him. He says it can be 2 or 3 people talking at one time outside his door, threatening him. He says he takes a knife into his room and stays there until he feels safe. He says he would use the knife if necessary.

Other relevant information re current situation (e.g. collateral from other agencies)

5. Personal History inc Trauma History

Reports a normal upbringing, no problems at school. Left school and went straight into the army. When he left the army, he worked as an engineer. Once retired, had a few security jobs.

Previously married and has two sons who live in West Lothian.

Family History of Mental Health Problems

None known.

6. Social Circumstances

Self Care / Home Management / Finance/ Debt / Risk Of Homelessness

Meaningful Activity / Educational History / Employment History / Employment At Risk? / Leisure Pursuits

Lives in a one bedroomed flat owned by housing association since 1998. Keeps the flat very clean and organised. No problems with self care.

Can make friends but does not have an oppourtunity. Has no regular friends, only aquaintences.

In receipt of ESA and 2xpensions. Reports no debt. Manages his money well.

No meaningful activity

7. History of Mental Health Problems inc Past Interventions:

Reports 20+ years of depression which he “just dealt with”. However, things got worse 5/6 years ago and he first made contact with his GP.

No other mental health issues reported.

Surname:
First name:
DOB:
CHI:
or affix patient ID label

MENTAL HEALTH
SINGLE ASSESSMENT

8. Physical Health, Medication

Medical History / Current Physical Health Concerns

Psoraisis face- treated with hydrocortisone cream. Only flares up when stressed. None present today.

Current Medication (Including Over The Counter Medicines, Note Name, Frequency, Dosage, Concordance)

Mirtazapine 15mg od

Haloperidol 1.5mg twice daily

Diazepam 5mg twice daily

Zopiclone 7.5mg od

Note Preferred Local Pharmacy

Sources Of Information: Service User ☒ Carer ☐ GP☐ Pharmacist ☐ Notes ☐

Other ☐ Specify Other:

9. Alcohol / Substance Use

Alcohol Use (Note Frequency, Weekly Number Of Units):

Other Substance Use (Note Type, Quantity, Frequency, Route Of Administration):

Sometimes binge drinks. Has cut down now.

Usually 8-10 bottles 500ml beer at one sitting

Risk Of Dependence / Withdrawal: Yes ☐ No ☒

Details of Withdrawal Risk

Prescribed Substitute? Yes ☐ No ☒ Details

If Yes: Details Of Who Dispenses:

Never Smoked ☐ Ex-Smoker.☒ Current Smoker ☐ No. Of Cigarettes Per Day _____

If Smoker: Brief Intervention Given? Yes ☐ No ☒

Surname:
First name:
DOB:
CHI:
or affix patient ID label

MENTAL HEALTH
SINGLE ASSESSMENT

10. Current Mental State
Appearance & Behaviour Very well kept and remained calm and relaxed throughout. No fidgety behaviour or distraction noted. Flat really clean and in order.
Speech & Communication Speech was normal although monotonic. Able to clearly communicate needs.
Mood, Inc Suicidal Ideation Mood objectively flat No current suicidal ideation but says fleeting thoughts.
Sleep Pattern / Energy Levels / Motivation /Appetite Poor sleep and appetite. Lacks motivation however attends VFP and SAMH on a Tuesday. Can get out and do his shopping ok.
Thought Content / Abnormal Beliefs / Thought Disorder; Abnormal Experiences; Obsessions / Compulsion / Checking / Rituals No evidence of psychotic symptoms today. No thought disorder or abnormal beliefs. Psychotic symptoms are reported, not witnessed. Ronnie reports an improvement since taking medication and would like stronger ones.
Concentration / Attention Span / Memory All appeared intact.
Insight, Judgement Very insightful and happy to engage in medicinal treatment. Not so keen on psychological therapies at the moment.

Surname:
First name:
DOB:
CHI:
or affix patient ID label

MENTAL HEALTH
SINGLE ASSESSMENT

11. RISK FACTORS Tick if Stand Alone Risk Assessment Completed ☐

Identify all from Risk Factor List inc. Historical (From Risk History); Service User's Expression Of Risk
Other Contextual Factors e.g. Housing, Relationships, Loss Of Role, Physical Illness

RISK TO SELF Previous Self Harm/Suicide Attempts, Family History Of Suicide, Socially Isolated, Planning Suicide, Access To Specific Lethal Method (e.g. weapons, medication), Hopelessness — Yes ☐ No ☐ Not Known ☒

No current thoughts of self harm or suicide. Reports fleeting thoughts when experiencing psychotic symptoms. No plans.

Depression.

Lives alone.

RISK TO OTHERS Previous Violent Acts, Use Of/ Access To Weapons, Previous Admission To Secure Unit, Intoxicated; Convictions For Violence, Supervision Failure, Known Fire Risk — Yes ☐ No ☐ Not Known ☒

Denies previous or current thoughts to harm others. However, reports holding a knife when he believes he is in danger with intent to use.

RISK FROM OTHERS Abuse, Exploitation, Domestic Violence, Neglect — Yes ☐ No ☒ Not Known ☐

GBV Routine Enquiry assessed Yes ☐ No ☐ Data entered onto TRAK Yes ☐ No ☐

Further investigation required? Yes ☐ No ☐ By Whom?:

RISK TO CHILD(REN) Neglect, Abuse, Child Included In Suicide Plans, Delusional Thinking — Yes ☐ No ☒ Not Known ☐

A consultant psychiatrist should be directly involved in all clinical decision making for those who may pose a risk to children

RISK OF SELF NEGLECT Health, Memory, Cognitive Impairment, Physical Impairment — Yes ☐ No ☒ Not Known ☐

RISKS RELEVANT TO SERVICE PROVIDERS Risks To Staff, Circumstantial Or Environmental Risks Identified For Visiting Staff — Yes ☐ No ☒ Not Known ☐

Surname: **MENTAL HEALTH**
First name: **SINGLE ASSESSMENT**
DOB:
CHI:
or affix patient ID label

12. Carer's Information

Tick if No Carer and go to 14 ☒

Carer's usual role in supporting person

Carer's view of current situation

Carer's View Of Risk

Carer's Desired Immediate Outcome(s):

13. Summary

Person's Desired Immediate Outcome(S):

Wants stronger medications and more support.

Summary (Inc summary of risk, current needs, protective factors and precipitating / perpetuating factors

60 year old man with depression and anxiety reporting psychotic symptoms. Lives alone with limited contact with family. Has no friends and developed a bit of social phobia.

Has no current meaningful activity or distraction. Drinks a lot of alcohol on occasion. Has no criminal history or thoughts to harm other people. Reports he holds a knife and retreats into his room for days when he believes he is under threat. No obvious trigger to these episodes. Reports since starting the medication, the psychotic symptoms have lessened but would like stronger ones.

Formulation /diagnosis

Depression with reports of psychotic symptoms.

Surname:
First name:
DOB:
CHI:
or affix patient ID label

MENTAL HEALTH
SINGLE ASSESSMENT

14. Plan

Management Plan (Inc Risk Plan)

Taken on to CMHT caseload for brief intervention.
Offered anxiety management but declined.
Offered referral for a support worker but not keen at the moment.
Monitor for signs of psychotic symptoms and response to medication.
Attempt to explore interests to build confidence going outdoors.
Meet 2/52 initially with regular review.
Liase with MDT and Ronnie with regards to changes in treatment plans.

If family friends or carers involved in plan do they fully understand and consent to this?
Yes ☐ No ☐ N/A ☒

Have family friends or carers involved in plan details of how to contact service Yes ☐ No ☒ N/A ☐

If referred for psychiatric admission, is person medically suitable? Yes ☐ No ☐ N/A ☐
Comment:

Assessment discussed / shared with: Dr Cooper

16. Sources of information used:

Tick if mental health record not available ☐

Mental Health Record ☐	TRAK☒	Service User ☒	Family / Carer ☐	Others ☐
Vols:				Specify:

17. Assessor Details

Referred by:

Assessing team: SW CMHT	Time of assessment (24hr clock): 1100	Location of assessment: H/V
Primary assessor: Tracey Johnstone	Designation: CPN	Signed:

Surname:
First name:
DOB:
CHI:
or affix patient ID label

MENTAL HEALTH
SINGLE ASSESSMENT

2nd assessor:	Designation:	

NHS Lothian

Cambridge Street House
5/7 Cambridge Street
Edinburgh
EH1 2DY

Adult Mental Health SW OPD

Dr Murray
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 07/12/2020

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (62 years) 600086642R
Attendance Date	16/11/2020		
Consultant	Dr Deborah J Cooper		

Dear Dr Murray

Ronald McRobb / CHI 3012571450

Psychiatric Diagnosis:
1. Psychosis not otherwise specified (currently no evidence of psychotic symptoms).

Current Psychiatric Medication:
1. Aripiprazole 20mg.
2. Fluoxetine 20mg.
3. Mirtazapine 15mg.
4. Please stop Melatonin, not taking.

I met with Mr McRobb for a telephone consultation on the 16th November. Although he describes his chronic difficulties with his mood and anxiety, sleep has improved and he is no longer using Melatonin, taking this on an as required basis for anxiety. He was able to accept that it would not be useful in this regard and any effect he was gaining was more likely to be placebo. Ive suggested the Melatonin is stopped. He was very mildly anaemic when in the Royal Edinburgh and due to complaints and due to complaints of fatigue and low energy I thought it would be worth checking this. He wonders of he might have low testosterone (something he has had in the past and I suggested I would bring this to your attention as to whether this could be checked).

Plan:
1. No change to medication.
2. Id be grateful if he could have check of full blood count, Us and Es, LFTs, Cholesterol and Glucose. I will leave it to your discretion with regards to the testosterone.
3. I will review him in 6 months.

Yours sincerely

Dr Deborah Cooper
Consultant Psychiatrist

NHS Lothian

Cambridge Street House
5/7 Cambridge Street
Edinburgh
EH1 2DY

Dr Murray
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 05/03/2020

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI**	**3012571450**
		Date of Birth / Age	30/12/1957 (62 years)
		UHPI	600086642R
Specialty	Adult Mental Health SW OPD	**Attendance Date**	10/02/2020
Consultant	Dr Deborah J Cooper		

Dear Dr Murray

Mr McRobb's appointment was cancelled on 10th February 2020 as he is currently an inpatient in the Royal Edinburgh Hospital.

I will send him out a further appointment and he is likely to be followed up by IHTT on discharge. Failing that, CPN Tracey Johnston will make contact.

Yours sincerely,

Dr Deborah Cooper
Consultant Psychiatrist

NHS Lothian

Royal Edinburgh Hospital
Morningside Place
Edinburgh
EH10 5HF

Dr Murray
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 14/02/2020

Inpatient Discharge Summary

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (62 years) 600086642R
Specialty	AMH Adult Mental Health	**Admission Date**	01/01/2020
Ward	REH - Merchiston		
Consultant	Dr Pauline M McConville	**Discharge Date**	11/02/2020

Dear Dr Murray

Discharge Drugs

Discharge Medication	Dose	Frequency	Duration	Additional Info
Aripiprazole Tablets	15 MG	In the MORNING	Long Term	
Enstilar Foam, 1 application, topical		In the MORNING	4 Weeks	for 4 weeks (started 28/1/20) as per dermatology advice. Apply topically to face, scalp & neck
Fluoxetine Capsules	20 MG	In the MORNING	Long Term	
Melatonin (Circadin) M/R Tablets	2 MG	At NIGHT	Long Term	
Zerobase_cream	1 APPLY	TWICE DAILY	Long Term	At 8am and 10pm

DIAGNOSES / PROBLEM LIST
paranoid psychosis

MENTAL HEALTH ACT STATUS
Informal

TREATMENT ON THE WARD
Mr Robb was brought to MHAS by the police last night after approaching his neighbour with a knife. He reported various paranoid beliefs to the police and admitting doctor stating that he had been held hostage, that "terrorists" were planning to "take him out". Very distressed on initial assessment feeling that his safety was under significant threat, stating that gas was being put into his house that was poisonous and that his food was also being poisoned. On admission to the ward Mr McRobb remained suspicious and on edge. Refused to sleep as believed that would be dangerous and instead kept watch.

Mr Robb was restarted on his regular medications on admission, however, his Sertraline was reduced and stopped as it appears to

have been played a role in 2x presentations to hospital. Queltiapine was initially increased, however Mr Robb remained paranoid and suspicous so it was decided to cross titrate this with Aripiprazole.

Mr McRobb has psoriasis which was discussed with on-call Dermatology while an in-patient, for psoriasis on face/neck/scalp. They recommended starting Enstillar Foam 1 app daily for up to four weeks and for an urgent dermatology appointment to be arranged, which has been done.

Mr Robb's mental state appeared to improve on Aripiprazole and Fluoxetine. He engaged well with the ward team and utilised pass appropropriately. Mr Robb is now stable for discharge.

FUTURE INVESTIGATIONS
Referred for urgent dermatology outpatient appointment

FOLLOW-UP BEING ARRANGED BY HOSPITAL
CMHT

CHANGES TO DRUGS SINCE ADMISSION
Quetiapine stopped
Sertraline stopped
Aripiprazole started and increased to 15mg OM
Fluoxetine started at 20mg OM
Enstilar Foam started as per dermatology advice for psoriasis
Zerobase Cream commenced, BD
Melatonin 2mg commenced at night.

ALLERGIES / ADVERSE DRUG REACTIONS
Diclofenac

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS
Nil

DRVING ADVICE GIVEN: Written/Verbal/Doesn't Drive/Not Done

GP PLEASE CONSIDER THE FOLLOWING

NAME:

DESIGNATION:

This is an immediate discharge letter and a further letter may follow.

Dr Murray
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Merchiston Ward
Royal Edinburgh Building
Royal Edinburgh Hospital
Morningside Terrace
Edinburgh
EH10 5HF

Date Rec'd: 5th March 2020
Date Typed: 6th March 2020
CHI: GJ/KW/136931
Our Ref: 3012571450

Enquiries to: **Shona Lobban**
Direct Line: **0131 286 9149**

Dear Dr Murray

Re: Ronald McRobb DOB: 30/12/1957
8/5 Northcote Street, Edinburgh, EH11 2HL

Date of Admission:	**01/01/20**
Date of Discharge:	**11/02/20**
Hospital Consultant:	**Dr Pauline McConville**
Legal Status in Hospital:	**Informal**
Legal Status on Discharge:	**Informal**
Suspension of Hospital Stay:	**Nil**
Diagnoses:	**Psychosis** **Social phobia**
Medication on Discharge:	**Aripiprazole 15 mg in the morning** **Fluoxetine 20 mg in the morning** **Melatonin (Circadin) M/R 2 mg at night** **Enstilar Foam 1 application topical in the morning for four weeks, apply topically to face, scalp and neck** **Zerobase cream 1 application twice daily at 8.00am and 10.00pm**
Community Consultant and Team:	**Dr Cooper** **CPN Tracey Johnstone**
Follow Up Arrangements:	**CPN, Tracey Johnstone**

Presenting complaint and circumstances of admission
Mr McRobb presented after stating the he believed that he was being held captive. Mr McRobb was brought in by the police to the Royal Edinburgh Hospital after going upstairs to his neighbour's home whilst brandishing a kitchen knife. His neighbour was able to shut the door and phone the police. When police arrived they found Mr McRobb calm and amenable to coming with them to MHAS although he was wearing handcuffs on arrival. Mr McRobb reported various paranoid beliefs to the police and to the admitting doctor. He stated that he had been held hostage and that "terrorists" were planning to "take him out". He was very distressed on initial assessment feeling that his safety was under significant threat. He also stated that gas was being put into his house that was poisonous and that his food had also being poisoned. Mr McRobb stated that the terrorists had got mixed up between him and another Ronald McRobb who are both veterans. Mr McRobb stated that he knew they were after him as four weeks ago he saw a white van parked outside. The delivery driver who was delivering food to him at the same time looked up suddenly whilst standing at the door. Mr McRobb was watching through the keyhole and knew that people were there. Mr McRobb reported he held up the house for 33 days as he did not feel safe. He had also discouraged his son from visiting him as he was extremely worried his son would get killed.

Medication on admission, substance use, sensitivities to medication, allergies
Sertraline
Quetiapine modified release

Past psychiatric history
Mr McRobb was first referred to IHTT in February 2017 with psychotic symptoms and thoughts of being poisoned. He also had sleep disturbance. The plan in February 2017 was to continue Olanzapine and Diazepam was also initiated. He was advised to abstain from alcohol. He was also to be followed up with Veterans First Point. When First Point assessed him they felt it was a mix of anxiety, depression, ongoing alcohol misuse and he was referred to psychology. He was started on Risperidone by the psychology team at First Point as Olanzapine was making him edgy. He was then seen by Dr Cooper in February 2018. It was felt that he was having brief psychotic episodes linked with poor sleep and alcohol misuse. The Olanzapine was increased before trying Haloperidol in April 2018 and then Quetiapine in August 2018 with good effect. The voices became quieter once on Quetiapine. The Mirtazapine he had initially been put on was switched to Sertraline in April 2019 due to concerns with weight gain on a combination of Mirtazapine and Quetiapine. Mr McRobb was also prescribed Diazepam for anxiety symptoms but Mr McRobb felt he was becoming dependent on the Diazepam. It has been withdrawn slowly over the two months leading up to admission to hospital with an accompanying increase in Quetiapine. Mr McRobb had MoCA's in 2018 and 2019 and both scores were 23 out of 30.

Past medical history
McRobb has a history of severe psoriasis and he has been seen by the dermatology at Lauriston Place.

Family history
Nil family history noted.

Personal history
Mr McRobb was born in Edinburgh but grew up in a Children's Home in North Berwick after his parents separated. He has never seen his mother but his father used to visit from time to time. His father had a known alcohol problem. Mr McRobb has one brother who lives locally but Mr McRobb has little contact with him. Mr McRobb met his sister around 30 years ago after she made contact with him but he has not seen her since. Mr McRobb reports a good life in the Children's Home with structure and routine. He enjoyed school with only occasional bullying and said he knew how to take care of himself. Upon leaving school Mr McRobb did a couple of jobs before joining the Army when he was in his 20s and enjoyed it especially the regimented nature. He left after 12 years as he was being posted to Germany and his wife was pregnant with their second child. Mr McRobb has a son and a daughter and his daughter has three children who live in West Lothian. He is in regular telephone contact with his daughter and children but only sees them infrequently due to his social anxiety and because he avoids public transport. Mr McRobb separated from his wife in 1993 after 14 years of marriage stating that they grew apart. His wife has since remarried. Since leaving the Army Mr McRobb has had different jobs the last being in an oatcake factory from which he was made redundant last year.

Mental state on admission
Mr McRobb was dressed in pyjamas with a white t-shirt and housecoat. He sat during the interview with his handcuffs on. He appeared older than his years with white hair, glasses and heavily tattooed arms. He was easy to engage with and had intense eye contact. He had a relaxed manner with a normal level of psychomotor activity although later on, on the ward, he was pacing and staring at the ceiling voicing concerns of people on the roof.

Speech - Mr McRobb had a normal rate, rhythm and volume to his speech which became quicker when talking about his perceived threat otherwise he was conversational. Mr McRobb's mood was rated as low due to recent stress. Objectively though he appeared euthymic. He had a reactive affect. Mr McRobb's thought form was repetitive when speaking about his persecutory delusions and people trying to kill and poison hm. He also had delusions of reference regarding the white van in the driveway and people coming to kill him. He had nil formal thought disorder.

Abnormal perceptions - Mr McRobb stated he was able to hear voices from the flat talking about him, how to dispose of his body and also had seen gas coming through the smoke alarm. He also stated that on occasion he had seen three gangsters in his house and heard them but was unsure where they went. On the ward he also reported talking to people who were trying to say "I know where you are".

Cognitive functioning - Mr McRobb was orientated as to time, place and person with the correct date, day of the week, season and year, address, date of birth and age. He showed good attention and concentration throughout the interview.

Insight - Mr McRobb on admission felt he was physically unwell from inhaling the gas but denied anything else stating that he was “compos mentis”. He stated that he was happy to come into hospital on the basis that it was safe and was accepting of his evening medication.

Physical assessment on admission, including results of investigations

1. Cardiovascular - normal
2. Respiratory - normal
3. GI - abdomen descended but soft, no masses nor tenderness on palpation
4. Neurological examination - normal
5. Cranial nerves - normal

It was observed that he has psoriatic plaques seen all over his body but did not report concern with these.

Initial formulation

Mr McRobb had predisposing family history of alcohol problems, alcohol use himself and PTSD. Precipitating causes were social isolation, his use of alcohol and his non-compliance with his medications. Perpetuating again was his non-compliance with his mediations, his ongoing alcohol use, his lack of sleep and his lack of engagement with the psychological services.

Progress and treatment on the ward

In hospital Mr McRobb’s sleep was good and his appetite was fine. His concentration was also good whilst watching TV and films. At first Mr McRobb continued to state adamantly that “this is really happening to me, part of me wishes this is all not true”. He informed staff that he continued to hear the gangsters in the ceiling whispering about him and that this was worse at night. Whilst on the ward his Quetiapine was increased to 600 mg and his Sertraline was reduced to 100 mg. He once used Lorazepam as a second line to oral Quetiapine. He also had daily room checks with a particular focus on cutlery and/or other items designed for self defence. Later on during his time in hospital his Quetiapine was switched to Aripiprazole. Mr McRobb’s psoriasis was also discussed with the dermatology team and he was commenced on Enstilar Foam - once a day for four weeks. In late January 2020 he was still showing evidence of paranoia and still had concerns about someone breaking into his flat but his mood was bright and reactive and he was interacting well with staff members and spending time in the communal areas. His Aripiprazole was increased to 15 mg and he was commenced on Fluoxetine. His OT assessment was successful. In early February Mr McRobb felt that he was much better in regard to his psychotic symptoms but still felt anxious. He described his anxiety as a longstanding issue and that he had experienced social anxiety for years prior to admission. He has a very rigid schedule that he keeps to at home and if he has to do something out with his usual plan he will carefully plan a route which will be the quietest with regards to other people. He has unable to travel on trains to visit his children who live in Fife secondary to this anxiety. Later on in his admission Ronnie reported initial insomnia and then wakening early around 5am or 6am each day though nursing reports that he is sleeping upon night-time checks. His passes went well although he did feel anxious travelling by himself out with the hospital grounds. He was trialled with Melatonin in order to help his sleep. IHTT came to review Mr McRobb. In the end it was felt that he was not appropriate for IHTT. His next contact was to be CPN Tracey Johnstone.

Mental state on discharge

On discharge Mr McRobb was calm and relaxed. His skin was clear of acne and psoriasis which had bothered him during his admission. He had a jovial manner, he had succinct answers to questions, he was anxious when discussing his discharge and hesitant around moving on but recalled discussions held earlier in the week and was on board with the plan for discharge. His mood was fine on the ward and he was objectively euthymic and appropriately reactive albeit anxious when discussing discharge. He described hearing whispering at night-time but reflects that “it is just me over thinking when I hear people outside talking”. He denied any symptoms during the day time and denied delusional ideas pertaining to gangsters. He refers to his time in hospital as “one of my psychotic episodes”. He was accepting of the explanation of his anxieties and his unchecked worries and his overvalued ideas evolving into psychosis. His ACE during admission was 96 out of 100.

Risks (including driving) and prognosis
Risks are to himself if not complaint with medication and potential risk to others if becoming psychotic again.

Discharge Planning Meeting and follow up arrangements
Mr McRobb was not seen as appropriate for IHTT therefore his next contact will be Tracey Johnstone, his CPN.

Changes to his drugs since admission -

1. Quetiapine - stopped
2. Sertraline - stopped
3. Aripiprazole - commenced and increased to 15 mg
4. Fluoxetine - started at 20mg
5. Enstilar Foam - started
6. Zerobase Cream - commenced
7. Melatonin - commenced at night

He will also have follow up with CMHT in the community and he has been referred for an urgent dermatology outpatient appointment. Driving advice - not given.

Yours sincerely

Dr Greta Jacobsen
FY2 to Dr McConville

Dr Pauline McConville
Consultant Psychiatrist

NHS Lothian
Adult Acute Mental Health
Occupational Therapy Service
Initial Assessment

Patient's Name: Ronald McRobb		Date of Interview: 30/01/20
Consultants Name: Dr McConville		Date of Birth: 30/12/57
Therapist's Name: Marcus Claridge		CHI: 3012571450
Reasons for referral to Occupational Therapy: Functional and home assessment for adaptations.		History of presenting condition: Ronnie has experienced longstanding depression and anxiety, and began experiencing brief psychotic episodes 3 years ago.
OT information provided	X	Risks identified: Aggression,self-negelct
Consent gained and documented	X	

The Model of Human Occupation Screening Tool

Motivation for Occupation				Pattern of Occupation				Communication & Interaction Skills				Process Skills				Motor Skills				Environment			
Appraisal of [illegible]	Expectation of [illegible]	Interest	Commitment	Routine	Adaptability	Roles	Responsibilities	Non-verbal skills	Conversation	Vocal expression	Relationships	Knowledge	Timing	Organisation	Problem-solving	Posture & Mobility	Co-ordination	Strength & Effort	Energy	Physical space	Physical resources	Social Groups	Occupational [illegible]
F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
A	A	**A**	A	A	A	A	A	**A**	**A**	**A**	A	**A**	A	A	A	A	A	A	A	A	A	A	A
I	**I**	I	**I**	**I**	**I**	**I**	**I**	I	I	I	**I**	I	I	I	I	I	I	I	I	**I**	**I**	I	I
R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	**R**	R

Rating Scale

F	**Facilitates**	Facilitates occupational performance
A	**Allows**	Allows occupational participation
I	**Inhibits**	Inhibits occupational participation
R	**Restricts**	Restricts occupational participation

Motivation for Occupation *What things do you enjoy?* *Previous, current, future plans for engagement?* *What do you do well, are proud of?* *What things have been difficult?* *How do you handle challenging/difficult situations?* *Goals for now or in future? Support required*	Ronnie was motivated to meet with OT. He described himself as having strong willpower, having been able to abstain from drugs and alcohol despite previous addictions. He describes his motivation as being impacted by tiredness due to poor sleep, anxiety, and self-consciousness due to the skin condition affecting his face. These have been exacerbated by recent paranoia, leading to him spending most of his time at home, and ceasing previously valued activities such as swimming, running and gym use. He also enjoys cooking and reading, especially on military history. He would like to re-engage with these activities, but feels he might need some support to do so.
Pattern of Occupation *Current situation, prior to admission?* *What's your routine, now and previous to admission/illness?* *Satisfaction with routine?* *Self care, sleeping, eating, medication etc?* *Home care?* *Current or previous roles?* *Current or previous responsibilities?* *Ability to fulfil role expectations?*	Ronnie reports that he has not been in employment for "a couple of years", having previously worked in Nairn's Oatcakes, from which he was made redundant due to mechanisation of processes. He has also worked as a gate security guard, but would not like to return to this, and was in the army in his youth. Ronnie's pattern of activity changed markedly with the onset of psychotic experiences, and he has self-isolated at home. He worked out quiet routes to the nearest shops, and has stuck to these, often using taxis for even short journeys. States he is unable to use buses and hasn't left Dalry for a long time. He became increasingly reliant on ready-meals or takeaways, having lost motivation to cook, but delivered food was often left on the doorstep as he was concerned that there may be people outside who wished him harm. He was very aware of loss of work, friendship, and family roles. Poor sleep has also impacted on his routines.
Communication and Interaction *Being with others* *Experience of being with others in groups?* *Preference for groups or individual?* *Feel able to express yourself?*	Ronnie was polite, spontaneous and showed evident interest in conversation. He was observed to come through to the communal area and sit with fellow patients following interview. He reports having a few close friends in the past, but having lost contact with them. He has tended to avoid busy spaces due to believing that others are talking about him.

Process skills *Do you feel you have any difficulties, mentally, which effect your ability to carry out day to day tasks?* *Feel able to plan, organise, problem solve? Decision making?* *Able to retain information?*	Anxiety, paranoia and lack of motivation have all impacted on day-to-day functioning. In discussing a task such as meal preparation however, Ronnie was able to describe necessary ingredients and stages within the task, and was motivated to take part in a cooking session with OT through which practical functional skills can be assessed.
Motor skills *Do you feel you have any difficulties, physically, which effect your ability to carry out day to day tasks?* *Bending, reaching, walking, transferring, balance?* *Co-ordination – stiff, fine motor etc?* *Strength – lifting, moving, gripping?* *How are your energy levels?*	Not assessed.
Environment *How do you feel about your environment (home, hospital etc), privacy, comfort, resources etc* *Feel safe? Ability to be independent? Finances?* *Access to social, leisure, work related spaces?* *Do you have social supports? Family, friends, colleagues etc?*	Ronnie has concerns about returning home due to feeling embarrassed about his behaviour prior to admission. He fears neighbours will be pointing him out as "a nutter with a knife", and will avoid him. He expresses a wish to re-engage in activities such as gym use however, and has an Edinburgh Leisure card to access this. He sees little of family or friends.
Plan: *Occupational Therapist name:* Marcus Claridge. *Sign:.Marcus Claridge* *Date:.31/01/20.*	• Assisted in downloading Feeling Good app to assist with anxiety symptoms and intrusive thoughts. • Functional assessment arranged for 3/2/20. • Engagement in hospital-based activity sessions. • Referred to Norrie Sloan, OT Technical Instructor to assist with community integration eg gym use or socially

	supportive environments post-discharge.

Surname: McRobb First names: Ronald CHI: 3012571450 DOB: *or affix patient ID label*	Ward: Merchiston	Date: 1/1/2020
	MEDICAL CLERKING History (Admitting doctor to complete on admission)	

Presenting complaint

Ive been held captive

History of presenting complaint

Brought in by police this evening after going up stairs to his neighbors brandishing a kitchen knife. Neighbor was able to shut the door and phone the police who found him calm and amenable to coming with them to MHAS though wearing hand cuffs.

Ron states that he has been held captive in his house for the last 33 days by 3 gangsters, John Shields, Jane Sheilds and Jimmy Gemmel. He states that they have got mixed up between him and another Ron McRobb (both are veterans) and they have been targetting the wrong Ron. They found about about him living there though a newspaper article.

States he knows they are after him as 4 weeks ago he saw a white van parked outside then he saw the lad who was delivering his chinese to him look up suddenly as he was watching him though the keyhole and he just knew that these people were there. Since then he reports he hasnt left the house as he doesnt feel safe and has discouraged his son to do the same as he is extremely worried his son may get killed.

He stated that these gangsters have also stolen £100,000 from him via the prudental but he is in the process of getting this sorted.

Says that they have been starting to poison his food, poisoning the first chinese that he had so has just been having flat bread and water since. Says that he has seen gas been leaked into this flat from the smoke alarm and there is a red light which he has seen on the alarm which follows him around the flat which is at risk of shooting something into the back of his neck.

He states they have been taking photos of him with cameras around the flat which have been put onto the internet and that they have been spreading propaganda about him being a pedophile. Says the SAS have been supporting him and that the bomb disposal squad will come and clear the flat this evening.

States that he doesnt feel safe in his flat and if he was to return then he would kill anyone who threatened him with the kitchen knives which he still has in his kitchen.

States has been feeling much lower in mood over the last 5 months though nil thoughts of self harm.

States has been taking his medications as they get delivered by dosette so he hasnt had to leave the house to get them.

History of presenting complaint (continued)

Surname: McRobb First name: Ronald CHI: 3012571450 DOB: *or affix patient ID label*	Ward: Merchiston	Date: 1/1/2020
	MEDICAL CLERKING History (Admitting doctor to complete on admission)	

Past Psychiatric History

First referred to IHTT Feb 2017 with psychotic symptoms (being poisoned) thought due to sleep disturbance (possibly due to increased sertraline???). Plan was to continue olanzepine and initiated diazepam, advised to abstain from alcohol and was to be followed up with veterans 1st point.

1st point felt it was a mix of anxiety, depression and ongoing alcohol misuse, refered to psychology.

Started on risperidone by the psych cons at 1st point as olanzepine is making him edgy

Seen by Dr Cooper in Feb 2018- felt having breif psychotic episodes linked with poor sleep and alcohol misuse- increased olanzepine, before trialling haloperidol 04/18 then quetiapine 08/18 with deemed good affect (voices quieter)

Mirtazepine switched to sertraline 04/19 due to concerns with weight gain of mirtazepine and quetiapine.

Was prescribed diazepam for anxiety symtpoms which he was deemed to be becoming ? dependent on but has been withdrawn slowly over last 2 months with an accompanying increase in quetiapine

Has had MOCA's 2018 and 2019 which have both been 23/30

Past Medical History

Psoriasis

Medicines Reconciliation

Document at least TWO sources ONE of which should be **patient, relative or carer**

Patient Relative or carer	☐ ☐	GP Practice	☐	Previous discharge letter Date:	☐	Emergency Care Summary (ECS)	✔	Other Specify……..	☐
Patient's Own Drugs	☐	Community pharmacy Tel:	☐	Recent OP letter Date:	☐	GP referral letter	☐	GP Repeats List	☐

Previous Adverse Reactions

Medicine/ Agent or Nil Known	Description of reaction
diclofenac??	

Medicines Prior to Presentation

Name of Prescribed Medicines	Dose	Frequency	Patient taking?	Please tick ONE box below			Comments Including reasons for withhold/ stop & when to restart following withholding
				Withhold	Stop	Continue	
Sertraline	200mg	mane	?			✔	
Quetiapine MR	600mg	nocte	?			✔	

HIGH RISK MEDICINE – ADDITIONAL REQUIRED DETAIL

CLOZAPINE: **Blood Test Freq?** **Last FBC date?** **Satisfactory?**

Treatment Break? **How long? (in hours)**

OPIOID SUBSTITUTE NAME: **Dose:** **Confirmed with:**

Supervised? Yes ☐ No ☐ Details of who dispenses:

LITHIUM: Form+ Brand used: **Recent plasma concentration?** **mmol/L** **Date:**

Please document further actions required in Initial plan

Completed by: Name (Print) creasy …… Signature: …….. Grade: CT2 ……..

Pharmacist Review by: Name (Print)…… Signature: …….. Date: ……..

Surname: McRobb First name: Ronald CHI: 3012571450 DOB: *or affix patient ID label*	Ward: Merchiston	Date: 1/1/2020
	MEDICAL CLERKING History (Admitting doctor to complete on admission)	

Family history

Personal & social history

(development, childhood, family circumstances, work, relationships)

(from IHTT 2017)

Briefly in his background Mr McRobb was born in Edinburgh but grew up in a children's home in North Berwick after his parents separated. He has never seen his mother but his father used to visit from time to time. His father had an alcohol problem. He has one brother who lives locally but has little contact with him. He met his sister around thirty years ago briefly after she made contact but has not seen her since. He reports a good life in the children's home with structure and routine. He enjoyed school with only occasional bullying but said her knew how to take care of himself. Upon leaving school he did a couple of jobs before joining the army where he was for twelve years and enjoyed it especially the regimented nature of it. He left after twelve years as he was being posted to Germany and his wife was pregnant with their second child and they did not see Germany as a good option for her. Mr McRobb has a son and a daughter (who has 3 children) who live in West Lothian. He is in regular telephone contact with them but only sees them infrequently citing his social anxiety as the reason he avoids public transport. He separated from his wife in 1993 after fourteen years of marriage saying they grew apart. She has since remarried. Since leaving the army Mr McRobb has had some different jobs, the last being at the Nairn oatcake factory from which he was made redundant last year.

For women only: Caring for child under 1 year old? Yes ☐ No ☐

If Yes: Management plan MUST include informing MWC that patient has not been admitted to MBU & why.

Does the person hold a current driving licence? Yes ☐ No ☐

Drugs & Alcohol history

Alcohol use (note frequency, weekly number of units and any history of withdrawal symptoms):

previous alcohol misuse- patient currently denies saying no drink for one year

Risk of dependence / withdrawal: Yes ☐ No ☐

Other substance use (note type, quantity, frequency, route of administration):

Prescribed substitute? Yes ☐ No ☐ If Yes: See above under medicines reconciliation

Risk of dependence / withdrawal: Yes ☐ No ☐ Risk of blood borne viruses: Yes ☐ No ☐

Smoking History

Never smoked ☐ Ex-smoker ☑ Current smoker ☐ Number of cigarettes per day _____

Others e.g. vapourisers	NRT required?	Yes ☐ No ☐

Forensic history

Never been arrested although the police informed me that if he was to be discharged tonight he would have been reprimanded in the cells and that we are to inform them when he is discharged.

Premorbid functioning / personality

Surname: McRobb First name: Ronald CHI: 3012571450 DOB: *or affix patient ID label*	Ward: Merchiston	Date: 1/1/2020
	MEDICAL CLERKING Mental State Examination (Admitting doctor to complete on admission)	

Appearance & behaviour

dressed in PJ, white t-shirt and house coat. sitting with cuffs on. Appears old for his years, rotund, white hair, glasses, heavily tattooed arms.

Easy to engage with good to the point of intense eye contact. Relaxed manner with normal level of psychomotor activity. Though later on ward pacing and staring at the ceiling voicing concerns of people in the roof.

Speech

Normal rate rhythm and volume, becoming quicker when talking about his perceived threat.
conversational

Mood & affect

Mood rates as low with the recent stress
ob- appears euthymic
affect- reactive

Thought form & content

Repetitive about his persecutory delusions re people trying to kill and poison him.
delusion of reference- white van in the drive way and people coming to kill him
Nil formal thought disorder

Abnormal perceptions

States able to hear voices from the flat about him talking about and how to dispose of his body.
States has seen the gas coming though the smoke alarm
states has on occasion seen the 3 gangsters in his house and heard them but unsure where they go.
on the ward seen talking to the people who are trying to get him saying "i know where you are"

Cognitive functioning

orientated to time place and person, correct date, day of the week, season and year, adress and date of birth and age
good attention and concerntration thoughout interview

Insight

Feels he is physically unwell from inhaling the gas but denies anything else stating he is compose mentus.
States is happy to come into hospital on the basis thats its safe, was accepting of his evening medication (quetiapine MR) though not of a sleeping tablet/lorazepam

Surname: McRobb First name: Ronald CHI: 3012571450 DOB: *or affix patient ID label*	Ward: Merchiston	Date: 1/1/2020
	MEDICAL CLERKING Physical Exam (Admitting doctor to complete on admission)	

Examining doctor's details:		
Name: Creasy	Grade: CT2	Signature:
If physical not completed on admission please give reason:		
Chaperone required Yes ☐ No ☐ If Yes details below		
Name	Designation	

Specific risk assessment for women of childbearing potential: Tick if not applicable ☐

Is patient using contraception?	Yes ☐ No ☐	Type:	
Could patient be pregnant?	Yes ☐ No ☐	Reason	
Is pregnancy test required?	Yes ☐ No ☐	Does patient consent to this?	Yes ☐ No ☐

Any specific complaints:

NIl

Systematic Examination:

Cardiovascular:

S1+2+0, cap refil under 2 seconds
moist mucous membranes
strong periferal pulses

Respiratory:

chest clear- good a/e thoughout

Gastrointestinal:

abdo distended but soft, nil masses or tenderness on palpation

Nervous System:	Tone	Power	Coordination	Sensation
R arm	✔	5	✔	✔
L arm	✔	5	✔	✔
R leg	✔	5	✔	✔
L leg	✔	5	✔	✔

Reflexes:	Triceps	Biceps	Supinator	Knee	Ankle
R	✔	✔	✔	✔	✔
L	✔	✔	✔	✔	✔

Cranial Nerves:
Grossly intact? Yes

If N, deficits found in:

Summary and comments:
psoratic plaques seen all over body- nil reports of concern with these
Further examination / investigations required:
bloods eCG

Examining doctor's details:		
Name:	Grade: CT2	Date: 1/1/2020
Signature:		Time:

Surname: McRobb First name: Ronald CHI: 3012571450 DOB: *or affix patient ID label*	Ward: Merchiston	Date: 1/1/2020
	MEDICAL CLERKING Summary and Plan (Admitting doctor to complete on admission)	

Summary

62 year old gentleman with an episode of paranoid delusions, auditory and possible visual hallucinations causing him enough distress and anxiety to take a knife to his neighbors door. It is unclear from the history whether he has been compliant with his medications or whether there has been any alcohol involved in his presentation. He had no insight into his current conditon and remains convinced there is an ongoing threat to his life and the life of his son. He is happy to come in to hospital as an voluntary patient.

Risk Summary

to him self- denies
to others- has stated that he will kill someone with a knife if he deems his life is at risk which he firmly believes.
risk of self neglect from not eating and drinking
risk from others who would try and defend them selves if he attacked

Formulation

Predisposing- FH alcohol problems, alcohol, PTSD,
Precipitating- social isolation, alcohol, non compliance
Perpetuating- ?non compliance, ?ongoing alcohol. lack of sleep, not engaging with psychological services

Working diagnosis / differential diagnosis

non specific psychotic episode

Initial Plan

(Please include investigations required / completed)

full physical and bloods
evening medications
PRN lorazepam and quetiapine IR 50mg
senior review
Zopiclone offered for night sedation
nursing reassurance
collateral from son/daughter- unable to get tonght as neither answering

Observation Level: General

Initial Pass Status: No pass

Further information required

Assessing doctor's details:		
Name:	Grade: CT2	Date: 1/1/2020
Signature:		Time:

Surname:**McRobb**
First name:**Ronald**
DOB:**30/12/57**
CHI:**3012571450**
or affix patient ID label

RISK ASSESSMENT LVL 1

Team SW CMHT

Date: 19/1/19

Time: 1130

RISK FACTORS Identify all from Risk Factor List including	**Historical factors** **Illness factors** **Contextual factors e.g. housing, relationships, loss of role, physical illness**

RISK TO SELF

Yes ☐ No ☐ Not Known ☒

Previous self harm/suicide attempts, family history of suicide, socially isolated, planning suicide, access to lethal method, hopelessness

No DSH/suicdal thoughts or acts documented.
Historical excessive alcohol abuse since the early 90's.
Cannabis use as a teenager.
Long standing anxiety and depression, tried on various antidepressants with little effect.
2015-first reported psychotic episode-hearing voices
2017- developed cellulitis and belived kids had been injecting him with keotone every night-called the police-breif intervention from IHTT. Quick resolve with some Olanzapine.
2018 to current -further psychotic episode reported, visual hallucinations of people outside his flat conspiring to kill him and his family. Barricaded self into bathroom armed with a knife. Believes neighbours are talking about him, planning to harm him. Says he has chased "someone" with a pole into the garden.

RISK TO OTHERS

Yes ☒ No ☐ Not Known ☐

Previous violent acts, use of / access to weapons, previous admission to secure unit, intoxicated; convictions for violence, supervision failure, known fire risk

None documented.
Previously in the army for 10 years, served during Irish conflicts.

RISK FROM OTHERS

Yes ☐ No ☒ Not Known ☐

Abuse, exploitation, domestic violence, neglect

RISK TO CHILD(REN)

Yes ☐ No ☒ Not Known ☐

Neglect, abuse, child included in suicide plans, delusional thinking

A consultant psychiatrist should be directly involved in all clinical decision making for those who may pose a risk to children

RISK OF SELF NEGLECT

Yes ☒ No ☐ Not Known ☐

Health, memory, cognitive impairment, physical impairment

Possible due to excessive alcohol abuse in the past. Can be quite repetative in recalling events/happenings.

RISKS RELEVANT TO SERVICE PROVIDERS Yes ☒ No ☐ Not Known ☐

e.g. risks to staff, circumstantial or environmental risks identified for visiting staff

Poor attendance for appointments.
Does not want psychological input. Has been offered CBT in the past, DNA.
High benzodiazepine dependance and seeking medicinal answers rather than psychological.

CARER'S VIEW OF RISK

LEVEL 1 RISK STATEMENT

What are the main risks; who are they to; how severe are they; what makes the risk worse; what protects against the risk

Ronnie presents as low risk currently.

Ronnie is has not harmed himself or others but becomes increasingly paranoid that people are out to get him and arms himself with weapons. Sleep is a big factor in the worsening of symptoms.

Ronnie is chronically anxious and depressed and has ben for a long time. He has sought help when things get bad for him, either police, his daughter or GP. His episodes do resolve and he is able to rationlise his thoughts and identify them as delusional/paranoid.

Ronnie has good insight and would do well if he felt in a position to engage in psychological work.

Safety / Risk Management Plan

Include plan if risks not known/further information needed

Complete staying well plan.

Ongoing suggestion of psychological work.

Avoid benzodiazepines where possible.

Encourage natural sleep hygiene.

Sources of information used: Tick if mental health record not available ☐				
Mental Health Record ☒ Vols:	TRAK ☒	Service User ☒	Family / Carer ☐	Others ☐ Specify:
Assessment discussed / shared with: Family / Carer ☐ Admitting doctor ☐ Ward Consultant ☐				

Community Consultant ☒ CPN/OT ☐ Social Worker ☐ Other ☐ Specify:				
Level 2 Risk Assessment indicated?	Yes ☐	No ☒	**Responsible team:**	

Designation	Name	Signature	Designation
Completed By	Tracey Johnstone		
Consultant	Dr D Cooper		Consultant

Review	**Date**
Change to Risk Factors?	
Change to Plan	

Designation	Name	Signature	Designation
Completed By			

Review	**Date**
Change to Risk Factors?	
Change to Plan	

Designation	Name	Signature	Designation
Completed By			

Review	**Date**
Change to Risk Factors?	

Change to Plan

Designation	Name	Signature	Designation
Completed By			

Suicide/Self-Harm	Violence	Other Risk Factors
HISTORICAL and SITUATIONAL FACTORS		
1. Previous self-harm Includes self harm coming to medical attention and actual suicide attempts.	**1. Previous violent acts** Serious or planned acts, that maybe came to others' (eg police, carers, medical) attention.	**1. Vulnerable due to learning disability** Not LD per se, but LD leading to potential risk to self
2. Use of violent methods	**2. Use of weapons**	**2. History of exploiting others**
3. Mental illness diagnosed	**3. Previous admission to secure units**	**3. History of being exploited**
4. Socially isolated	**4. Convictions for violence / assault** Includes homicide, attempted murder, bodily harm, common assault but not always breach of peace	**4. Previous history of falls**
5. Past diagnosis of personality disorder, or known impulsivity	**5. Past diagnosis personality disorder; psychopathy; known impulsivity** Psychopathy is classically characterised by impulsivity, callousness, criminal versatility, and a lack of remorse or empathy	**5. History of self-neglect or neglect of others** – children or other dependents This might be deliberate, or as a result of disability.
6. Major physical illness	**6. Alcohol or drug misuse**	**6. Lacks basic housing amenities** Water / heat / light. Is the absence of amenities beyond the individual's control?
7. Alcohol/drug misuse may require third party history to establish. What was purpose, and effect on behaviour of substance use?	**7. Male under 35**	**7. Previous known fire risk** Inadvertent or deliberate.
8. Family history of suicide	**8. Prior supervision failure** Major failures in parole, probation, or MHA compliance. Also, absconcion risk	**8. Socially or culturally isolated**
SHORT-TERM OR PRECIPITATING FACTORS		
9. History of treatment non-adherence	**9. History of treatment non-adherence**	**9. Eating disorder**
10. Planning suicide how detailed are the plans? Serious intent? Are there precautions against detection, and final goodbyes?	**10. Intoxicated** With drink or drugs at the time of assessment	**10. Difficulty communicating views** Speech or cognitive impairment, or cultural / language difficulties
11. Access to lethal method	**11. Acute positive psychosis** Includes destructive command hallucinations, referential paranoid delusions, and passivity phenomena	**11. Comprehension difficulties** Fluctuating level of consciousness, or delirium, as well as other cognitive impairment.

12. Hopeless / helpless Could be a manifestation of underlying low mood. Feels trapped or describes external locus of control?	**12. Violent fantasies**	**12. Confusion or disorientation**
13. Recent major loss Significant recent (< 1 month) life event, maybe with accompanying behavioural change.	**13. Identified target**	**13. Sexually disinhibited or aggressive** This must be directly witnessed, and be more than inappropriate comment.
14. Recent psych in-patient discharge Recent = <1 month, from acute psychiatric inpatient unit, whether planned or not	**14. Access to weapons** This may indicate the degree of planning	**14. Significant financial problems** It may not be the total debt value, but the impact of the debt that matters
15. Current / recent treatment non-adherence	**15. Current / recent treatment non-adherence**	**15. Current self-neglect**
PROTECTIVE FACTORS		
16. Willing to respond to advice/carers	**16. Willing to respond to advice**	**16. Willing to respond to advice/carers**
17. Has close relationship Is there someone (or a pet) who needs them or loves them?	**17. Availability of appropriate services** May be correctional or medical / rehabilitative.	**17. Availability of appropriate services** Medical, rehabilitative, or social services.
18. Religious beliefs Catholic and Jewish faiths said to be particularly protective.		

NHS Lothian

Cambridge Street House
5/7 Cambridge Street
Edinburgh
EH1 2DY

Dr McKechanie
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 11/09/2019

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (61 years) 600086642R
Specialty	Adult Mental Health SW OPD	**Attendance Date**	09/09/2019
Consultant	Dr Deborah J Cooper		

Dear Dr McKechanie

Psychiatric Diagnosis:
1. Organic Psychosis

Current Psychiatric Medication:
1. Quetiapine MR 600 mg
2. Mirtazapine 30 mg nocte
3. Sertraline 100 mg
4. Diazepam 5 mg mane plus 5 mg prn
5. Zopiclone 3.75 mg

I met with Mr McRobb on 9 September 2019 at Cambridge Street House.

His situation has shown limited improvement with medication though I do find him to be warmer and more reactive in clinic. He himself denies there has been any improvement and still feels very anxious. His routine is quite limited whereby he gets out of the house a couple of times a week for practical tasks and tends to use Diazepam to aid this. He is taking Diazepam each morning and then a few other times in the week when he is going out. I am concerned that this use will increase and does negatively impact on his cognition. He also continues to gain weight which is likely contributed to by his medication. There were no acute risks today.

He has made small gains through seeing Tracey Johnstone, CPN, and although I think he finds the contact positive, he has been very reluctant to consider doing concrete work such as anxiety management. With this in mind, Tracey is going to move on to do a Staying Well Plan with him and then will likely discharge him back to my clinic. I have repeated his cognitive screening today with the MOCCA assessment in which he scored 23/30 which is static from eighteen months ago.

Plan:
1. I would be grateful if Mirtazapine could reduce by 15 mg every two weeks until stopped.
2. At the same time please continue to escalate Sertraline by 50 mg to a dose of 200 mg, increasing in 50 mg increments every two weeks.
3. To try and limit his Diazepam use I would be grateful if in place of the extra Diazepam he uses for going out-and-about, he could try 25 mg to 50 mg immediate release Quetiapine in its place. Over time I would be hopeful that we would be able to reduce his Diazepam further.
4. I will organise to see him again in February 2020.

Kind regards.

Yours sincerely

Dr Deborah Cooper
Consultant Psychiatrist

NHS Lothian

Cambridge Street House
5/7 Cambridge Street
Edinburgh
EH1 2DY

Dr McKechanie
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 23/04/2019

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (61 years) 600086642R
Specialty	Adult Mental Health SW OPD	**Attendance Date**	08/04/2019
Consultant	Dr Deborah J Cooper		

Dear Dr McKechanie

Psychiatric Diagnosis:
1. Organic Psychosis

Current Psychiatric Medication:
1. Quetiapine MR 600 mg
2. Mirtazapine 45 mg nocte
3. Diazepam 5 mg prn
4. Zopiclone 7.5 mg prn

I met with Mr McRobb along with my attached medical student and Tracey Johnstone CPN on 8 April 2019.

Whilst he sees no objective improvements, overall I do see some. His psychotic symptoms appear less with no intense episodes where he locks himself in the bathroom because of distress. His voices are quieter. He has been left with quite a lot of anxiety and this is limiting his function to some extent. He has coped fairly well with significant stress related to his brother's ill health.

We have some concern about some weight gain (approximately 5 kg) since commencing Quetiapine. This will be exacerbated by the combination with Mirtazapine and we are having some thoughts about switching as outlined in the plan below. I did wonder whether it would be worthwhile considering prophylactic Metformin for him?

Overall I think things are improving. He remains quite focussed on medication as a solution but did engage well in the discussion today about the need for him to get back into exercise and activity.

Plan:
1. I would be grateful if we could add in Sertraline 50 mg once daily in the morning, increasing to 100 mg after two weeks. If this progresses well, then I would suggest consider cross-tapering from Mirtazapine to Sertraline. However, we will assess how he gets on with the initial introduction of this.
2. Ongoing CPN review.
3. Encouraged activity and exercise.
4. I will review him in the autumn.

Kind regards.

Yours sincerely

Dr Deborah Cooper
Consultant Psychiatrist

Cc Tracey Johnstone, CPN, Cambridge Street House

South West Community Mental Health Team

Dr A Chopra, Consultant Psychiatrist
Dr D Cooper, Consultant Psychiatrist
Dr N Forbes, Consultant Psychiatrist
Dr S Smith, Consultant Psychiatrist

Dr M O'Connor, Specialty Doctor in Psychiatry

Cambridge Street House
5 Cambridge Street
Edinburgh EH1 2DY

Tel: 0131 537 8650 / 8673

NHS Lothian

Date: 16 April 2019
CHI: 3012571450
Our Ref: DC/KC

Enquiries to: Kim Chapman (Secretary)
Direct Line: 0131 537 8693

Ms Denise Beck
Veteran Support Coordinator
Dunedin Harbour
6 Parliament Street
Edinburgh
EH6 6EB

Dear Ms Beck

Ronald McRobb, 8/5 Northcote Street, Edinburgh EH11 2JL

Thank you for your letter dated 14 March 2019 which for some reason only arrived at Cambridge Street House today.

Mr McRobb has a diagnosis of Psychosis Not Otherwise Specified. He attends Cambridge Street House for monitoring of his mental health which includes seeing myself in the outpatient clinic and receiving the support of Tracey Johnstone, CPN.

Mc McRobb is currently treated with the following medications:

Quetiapine MR 600 mg nocte
Mirtazapine 30 mg
Diazepam 5 mg prn
(I also understand he takes Lansoprazole for his physical health)

Mr McRobb has difficulties including significant anxiety which makes it difficult for him to leave his home and impactS on activities such as attending appointments and obtaining his medication. Whilst he has engaged well with us, his symptoms have not seen a full resolution. He does experience auditory hallucinations, though medication has led these to be slightly quieter. At times he can feel very threatened and this has led to him locking himself in parts of his home because of concerns that he will be attacked and harmed.

I hope this information is helpful in your support of his claim.

Kind regards.

Yours sincerely

Dr Deborah Cooper MB ChB MRCPsych Approved Medical Practitioner
Consultant Psychiatrist

NHS Lothian

Cambridge Street House
5/7 Cambridge Street
Edinburgh
EH1 2DY

Dr McKechanie
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 05/12/2018

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (60 years) 600086642R
Specialty	Adult Mental Health SW OPD	**Attendance Date**	03/12/2018
Consultant	Dr Deborah J Cooper		

Dear Dr McKechanie

Psychiatric Diagnosis:
1. Psychosis Not Otherwise Specified

Current Psychiatric Medication:
1. Quetiapine MR 400 mg nocte
2. Mirtazapine 30 mg
3. Diazepam 5 mg prn
4. Lansoprazole

I met with Mr McRobb at Cambridge Street House on 3 December 2018.

As you know, he is seeing Tracey Johnstone (CPN) on a fortnightly basis and also attends the Practice regularly for review. Overall, he could see a very slight improvement on Quetiapine and feels that his voices are quieter. They continue to take the same form which is that threats are made towards him and understandably he finds these distressing. Unfortunately, his daily activity is even more limited at the current time which is in part due to the closure of the local swimming pool and gym. This is due to reopen again soon and hopefully this will improve his activity levels.

We have had a discussion about the need for him to try and increase his activity and start to tackle some of his mental health in a behavioural way, rather than concentrating just on medication.

Opinion:
Overall, I did see increased reactivity and warmth today and he was more relaxed in demeanour than previous meetings. This is the first time I have seen any great response to medication (having previously tried Risperidone, Olanzapine and Haloperidol). I think we could continue his Quetiapine, but increase the dose as below.

Plan:
1. Please increase Quetiapine by 50 mg weekly to a dose of 600 mg.
2. I have encouraged him to engage in more activity.
3. I will review him again in around four months.

Kind regards.

Yours sincerely

Dr Deborah Cooper
Consultant Psychiatrist

Cc Tracey Johnstone, CPN, Cambridge Street House

NHS Lothian

Mental Health Services

Dr McKechanie
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 06/11/2018

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (60 years) 600086642R
Specialty	Adult Mental Health SW CMHT	**Attendance Date**	25/09/2018
Consultant	Tracey x Johnstone		

Dear Dr McKechanie

Psychiatric Diagnosis:
1. Treatment Resistant Schizophrenia

Current Psychiatric Medication:
1. Quetiapine 300 mg
2. Mirtazapine 30 mg

Plan:
1. Continue current medication.

The above patient attended Cambridge Street House on 25 September 2018 for their annual physical health check screening appointment.

Past Medical History:
Psoriasis, treated with topical cream.

Family History:
Nil

Current Non-Psychiatric Medication:
Topical creams for psoriasis.

Smoking Status:
Ex-smoker, stopped one year ago.

Bowel Function:
Has been experiencing constipation.

Reproductive Advice (women):
NA

Current Physical Activity:

Observations:
Weight: 84.9 kg
Waist Circumference: 44 cm
Height: 1.63 m
BMI: 31.9 (obese)
Pulse: 104 bpm
Blood pressure: 131/86

Glasgow Antipsychotic Side-Effect Scale (GASS):
Severe: Over the previous week Mr McRobb has felt sleepy during the day a few times, felt drugged or like a zombie once, felt his heart beating irregularly or unusually fast every day, has felt his muscles have been tense or jerky a few times, has felt his hands and arms have been shaky every day, has felt that his legs have been restless or he could not sit still a few times, has been drooling every day, movements or walking have been slower than usual a few times, vision blurry a few times, mouth dry every day, very thirsty and/or passing urine frequently every day, problems getting an erection every day.

ASSIGN Cardiovascular Risk Score:
14 (not high risk).

Blood Results:
FBC: normal
U&Es: normal
LFTs: normal
Lipid Profile: cholesterol 5.7, LDL cholesterol 3.4
HbA1c: 41

Electrocardiograph (ECG) Results:
QTc 421
Heart rate 99 bpm, sinus tachycardia
ECG with sinus tachycardia, otherwise normal

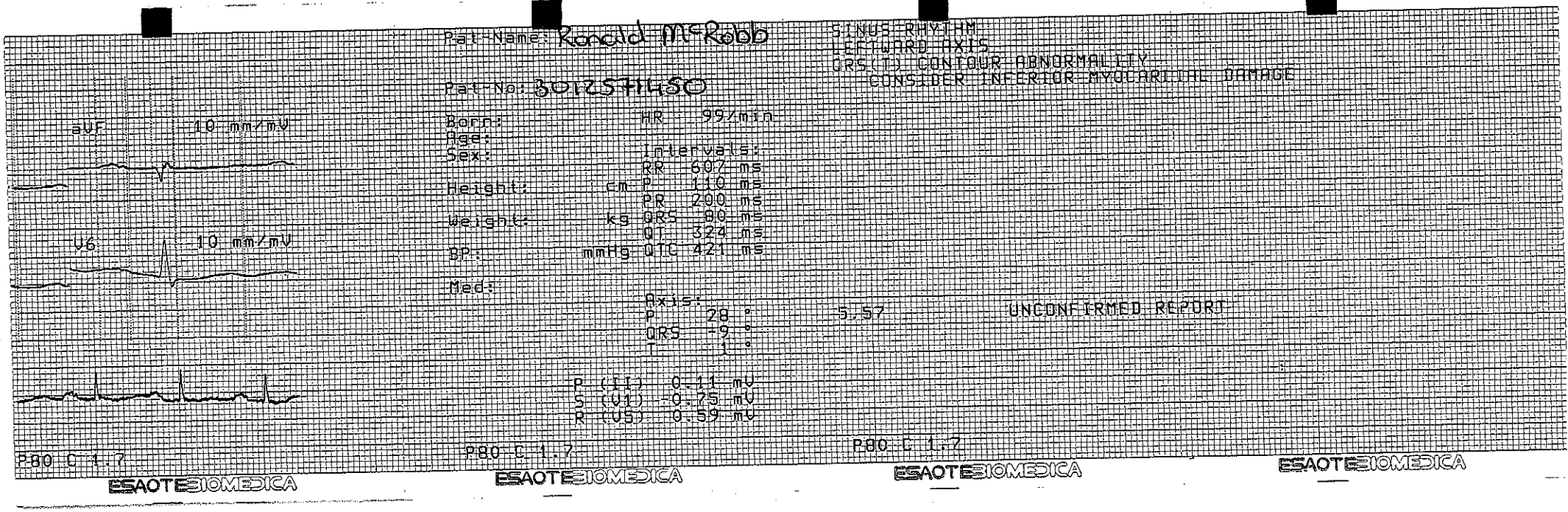
Interventions and Issues for Review:
Mr McRobb is experiencing severe side-effects of his antipsychotics and is particularly distressed by his excessive drooling and dry mouth. It is also notable that he is currently obese and is experiencing some exertional chest pain. We have given him information on how he could increase his exercise and improve his diet. We have also advised him to make an appointment with the GP if his exertional chest pain should continue.

If you have any queries, please do not hesitate to get in touch.

Best wishes.

Yours sincerely

Dr Peter Burnett
FY2 to Dr Mark O'Connor
Specialty Doctor in Psychiatry


Pat Name: Ronald McRobb
Pat No: 3012571450
Born:
Age:
Sex:
Height: cm
Weight: kg
BP: mmHg
Med:
HR 99/min
Intervals:
RR 607 ms
P 110 ms
PR 200 ms
QRS 90 ms
QT 324 ms
QTC 421 ms
Axis:
P 28 °
QRS -9 °
T 1 °
P (II) 0.11 mV
S (V1) -0.75 mV
R (V5) 0.59 mV
SINUS RHYTHM
LEFTWARD AXIS
QRS(T) CONTOUR ABNORMALITY
CONSIDER INFERIOR MYOCARDIAL DAMAGE
5.57
UNCONFIRMED REPORT
aVF 10 mm/mV
V6 10 mm/mV
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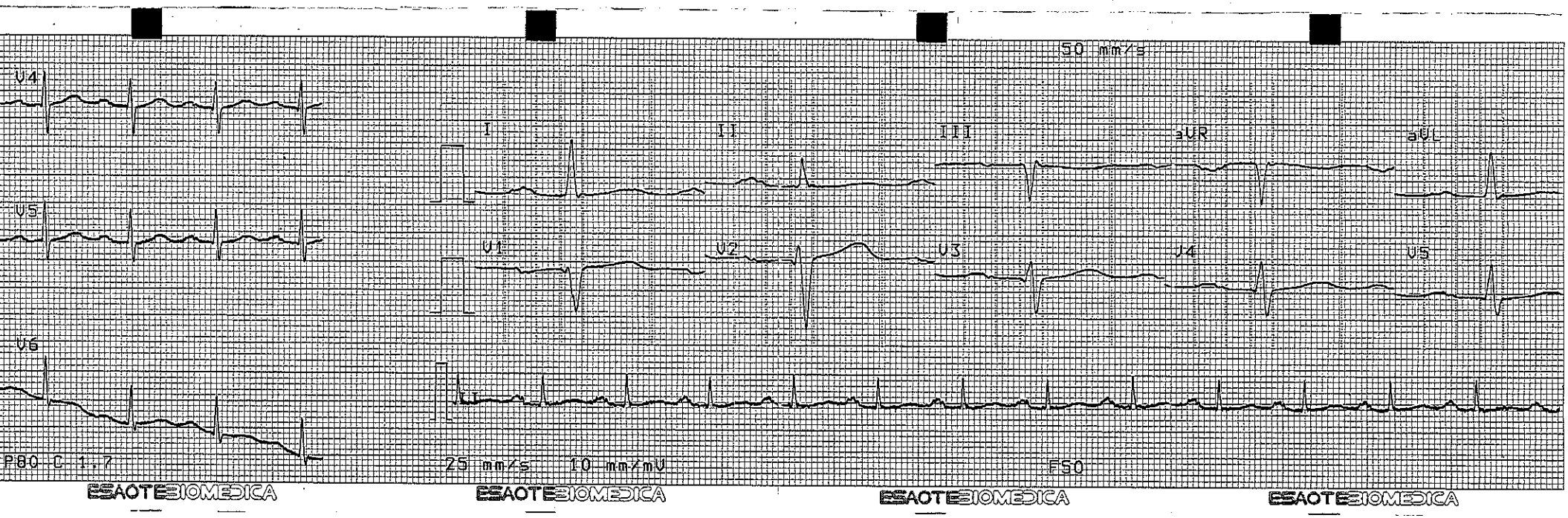
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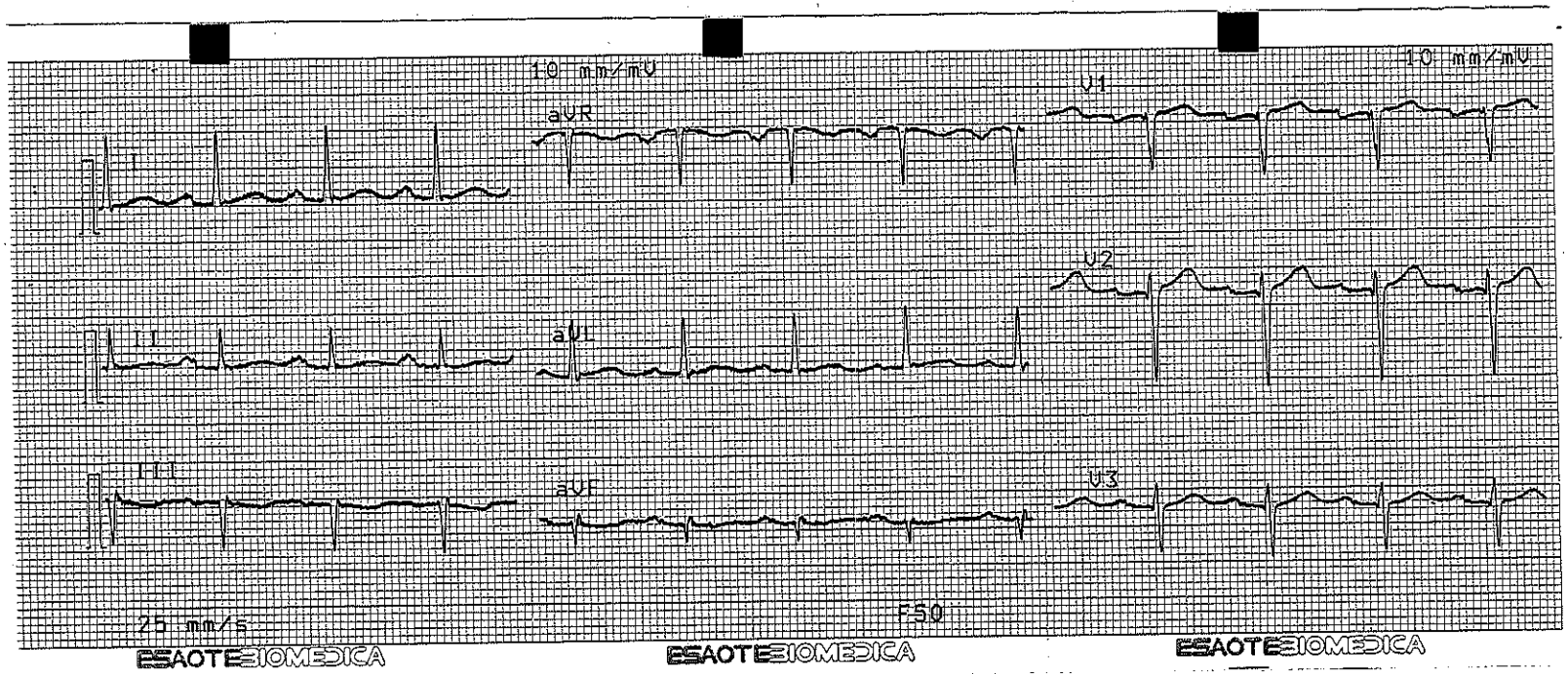
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NHS Lothian

Cambridge Street House
5/7 Cambridge Street
Edinburgh
EH1 2DY

Dr McKechanie
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 15/08/2018

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (60 years) 600086642R
Specialty	Adult Mental Health SW OPD	**Attendance Date**	02/08/2018
Consultant	Dr Deborah J Cooper		

Dear Dr McKechanie

Psychiatric Diagnosis:
1. Psychosis Not Otherwise Specified

Current Psychiatric Medication:
1. Haloperidol 2 mg bd
2. Mirtazapine 30 mg
3. Temazepam 10 mg nocte
4. Zopiclone 7.5 mg nocte
5. Diazepam 5 mg bd

I met with Mr McRobb at Cambridge Street House on 2 August 2018.

He has not felt significant benefit from medication. There has probably been some change with the Haloperidol in that he has not had the same number of intense feelings of paranoia that have previously caused him to retreat to his bathroom with knives from the kitchen. However, he continues to hear frightening hallucinations which say things like get him and tries to be very quiet in his flat to avoid being heard. Mood is described as low. He is describing extrapyramidal side-effects in terms of muscle stiffness and there was evidence of reduced facial reactivity at interview today. No acute risks were identified.

Plan:
1. I think we should try to switch to Quetiapine. This would have the added benefit of providing sedation at night time, an antidepressant effect as well as an antipsychotic effect. I would suggest Haloperidol is reduced by 1mg weekly until stopped. At the same time, he could commence Quetiapine MR 50 mg nocte and this could be increased every two to three days to a dose of 400 mg whilst the reduction in Haloperidol proceeds.
2. I suggested we reduce Zopiclone to 3.75 mg for two weeks and then stop. I remain concerned about the amount of benzodiazepines he is prescribed.
3. I will review him again in around three months but he has CPN monitoring from Tracey Johnstone in the meantime.

Kind regards.

Yours sincerely

Dr Deborah Cooper
Consultant Psychiatrist

Cc Tracey Johnstone, CPN, Cambridge Street House

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5/7 Cambridge Street
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Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
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Date: 25/05/2018

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (60 years) 600086642R
Specialty	Adult Mental Health SW OPD	**Attendance Date**	16/05/2018
Consultant	Dr Deborah J Cooper		

Dear Dr McKechanie

Psychiatric Diagnosis:
1. Psychosis Not Otherwise Specified

Current Psychiatric Medication:
1. Haloperidol 1.5 mg bd
2. Temazepam 10 mg nocte
3. Diazepam 5 mg prn
4. Please commence Mirtazapine 15 mg nocte

I met with Mr McRobb at Cambridge Street House on 16 May 2018.

There have been short lived periods of psychosis, for example where he becomes convinced that people are trying to break into his flat and hears voices where they discuss harming him directly. He describes feeling generally paranoid when out in the street but appears to retain insight into this and there are no clear delusional ideas. Sleep remains problematic, although he gets some sleep with Temazepam. He is leading very limited activity and exercise, spending much of the time inside.

There were no acute risks today, although he does feel he would like more support. Although he has had some input from Veterans First Point, I do think he would benefit from input from the Community Mental Health Team and I am going to ask the Team to consider.

Opinion:
Organic psychosis.

Plan:
1. I would be grateful if you could add in Mirtazapine to see if this could help with sleep, but also lead to some improvement in his mood.
2. I have organised to see him again myself in a couple of months but will ask the Community Mental Health Team if they will consider assessment for input from the Team.

Kind regards.

Yours sincerely

Dr Deborah Cooper
Consultant Psychiatrist

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Veterans' F1rst Point Lothian
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Tel: 0131 220 9920

Date: 8th May 2018

Duty Doctor
Colinton Road Surgery
296D Colinton Road
Edinburgh
EH130LB

Dear Duty Doctor

RE: Psychological Therapy; Ronald McRobb, 301 Colinton Road, Edinburgh, EH130LA
D.O.B 30.12.57

I am writing to update you on Mr McRobb's treatment and engagement with Veterans First Point (V1P). As you will know he was assessed by our service in June 2017 by Charlie Allanson-Oddy, Consultant Psychological Therapist. At this time he presented with a mixed presentation of anxiety and depression in the context of social situations. He also displayed difficulties with social isolation and binge drinking. Mr McRobb reported to me during our initial session that he had been admitted to hospital one month prior assessment following a mild psychotic experience thought to be a reaction to the medication he was taking and mixing this with alcohol. Mr McRobb reported that he believes he has difficulties with paranoia, believing that others are talking about him. Consequently he avoids going outside in the street on his own. He finds public transport difficult and had to travel by taxi to that assessment. Mr McRobb reports feeling anxious and a 'prisoner in his own home'. Following the assessment appointment Mr McRobb was recommended that he: be referred to Occupational Therapy within V1P for Individual Placement Support; he was offered a medication review by one of my psychiatry colleagues; he be referred to Erskine's Shoulder to Shoulder project for peer mentoring and he was advised to attend this service's drop in service which runs on Tuesday-Thursday 1:00-3:30pm in order to reduce his social isolation. Mr McRobb was also placed on our psychological therapy waiting list. I initially met with Mr McRobb on the 29th Nov 2017 in order to commence this work. Mr McRobb attended for eight times out of 12 offered appointments.

When I first met Mr McRobb it was evident that he continued to experience difficulties indicative of social anxiety and paranoia. He did not report having experienced any psychotic episodes in the time from assessment to meeting with me for the first time. However, throughout the course of psychological therapy there has been a lack of observed improvement but rather his mental health had been noted to deteriorate with him experiencing more psychotic episodes which seemed to coincide with him being re-prescribed olanzapine. He has been unable to attend therapy consistently recently and therefore I am discharging him from psychological therapy. However I will provide a summary of treatment and my clinical impression below.

Re: Ronald McRobb

Treatment

The plan was to meet on a weekly basis with the purpose of these sessions to use a cognitive behavioural approach with Mr McRobb. This involved psychoeducation on social anxiety, familarisation with the CBT model and developing more helpful coping strategies such as breathing techniques. Unfortunately we were unable to gain momentum with this intervention as a result of missed appointments.

In the latter stages of therapy Mr McRobb failed to attend and contact between us was brief via the telephone, with the last telephone contact on the 5th April 2018. During this telephone call Mr McRobb reported another psychotic episode and that it had lasted for at least two days. Mr McRobb asked for his daughter to make contact with the service. Mr McRobb's daughter spoke to myself about her concerns about her father as she said he had three psychotic episodes in the past week. This has not been confirmed by Mr McRobb directly. However, I was able to explore this further with Mr McRobb and we agreed that at present it was not practical for him to attend psychological therapy. I have since contacted his GP on 4th April 2018 and Dr. Cooper, Consultant Psychiatrist to provide an update on these recent developments.

Discharge

As aforementioned Mr McRobb has now been discharged from psychological therapy from the 5th April 2018. Mr McRobb has shown an increased understanding of his social anxiety and has been familiarised to the CBT model, however his psychosis symptoms have increased since the beginning of therapy and he has been unable to engage consistently with psychological therapy. It may be that if his psychotic symptoms are stabilised, there may be benefit to him re-engaging with psychological work.

Mr McRobb is aware that he still has access to the V1P service if he requires through his Peer Support Worker, he can attend drop in between 13:00-15:30pm on Tuesdays-Thursdays.

Should you have any queries or require any further information, please do not hesitate to contact me.

Yours sincerely,

Supervised by:

William Kirkpatrick
Counselling Psychologist in training

Dr. Lauren Forrest
Clinical Psychologist

Cc Ronald McRobb
Dr Deborah Cooper, Consultant Psychiatrist, Cambridge Street House

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Dr McKechanie
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
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EH11 2JL

Date: 23/04/2018

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (60 years) 600086642R
Specialty	Adult Mental Health SW OPD	**Attendance Date**	19/04/2018
Consultant	Dr Deborah J Cooper		

Dear Dr McKechanie

Psychiatric Diagnoses:
1. Psychosis Not Otherwise Specified
2. Possible Cognitive Impairment

Current Psychiatric Medication:
1. Olanzapine 15 mg
2. Diazepam 5 mg bd prn
3. Temazepam 10 mg nocte

I met with Mr McRobb at Cambridge Street House on 19 April 2018.

He had an Mental Health Assessment Service presentation last week when he felt distressed because of acute auditory hallucinations. He reports that these are perhaps more frequent than when we met the last time and he describes them as having a running commentary type form of a critical nature, but also being heard in internal space. However, on balance I think they are true hallucinations. I could elicit no other psychotic symptoms. He is anxious about going outside because of these voices, but I did not find him consistently depressed at interview.

At times he feels suicide would be easy. However, he has no intent to end his life and his family are protective. We checked a MOCA cognitive assessment today in which he scored 23/30, losing marks predominantly for recall. This might link to benzodiazepine use and we will simply monitor for now.

At interview, he was kempt, warm and relaxed. Eye contact was well maintained and speech was normal. He was not responding to unseen stimuli at interview but describes auditory hallucinations.
Hpwe

Opinion:
Mr McRobb presents with auditory hallucinations as primary psychotic symptom.

Plan:
1. He has not derived significant benefit from Olanzapine and has agreed to try Haloperidol as an alternative. I would be grateful if this could switch over as follows:
Week One: Haloperidol 1 mg bd, Olanzapine 10 mg
Week Two: Haloperidol 1 mg bd, Olanzapine 7.5 mg
Week Three: Haloperidol 1.5 mg bd, Olanzapine 5 mg
Week Four: Haloperidol 1.5 mg bd, stop Olanzapine.
I would be grateful if his medication could be put in a dosette box to ensure good concordance.

2. I will meet with him again in one month. If risks escalate or there is no improvement, I might consider referral to Community Mental Health Team for further assessment and support.
3. I will monitor cognition and consider further investigations moving forward.

Kind regards.

Yours sincerely

Dr Deborah Cooper
Consultant Psychiatrist

NHS Lothian

Mental Health Services

Dr McKechanie
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 23/04/2018

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (60 years) 600086642R
Specialty **Consultant**	AMH - MHAS Mhairi E McLaughlin	**Attendance Date**	04/04/2018

Dear Dr McKechanie

Mr McRobb self referred to MHAS having initially called the service earlier in the day. He states that he is "having an episode". He hears people talking about him "going to get me". He states that his mood is variable and that he has significant issues with anxiety. He currently lives alone and feels isolated. He believes that he is psychotic at present.

Psychiatric History
Seen by Dr Cooper as an outpatient and is next due to attend on 19th April 2018. Also previous contact with IHTT. Reported a previous episode of psychosis and is currently involved with psychology via the Veterans First Point.

No medical history.

Medication
Olanzapine 15mg
Diazepam 5mg BD
Temazepam 10mg at night

He states that he is concordant with his medication however does not feel that Olanzapine is effective.

Alcohol/Substances
Previous history of alcohol excess which he currently denies. Openly reports having had several beers during the most recent 6 nations rugby tournament. There was no evidence of intoxication at the time of assessment.

He currently lives alone in a Canmore flat and he has stayed there for 22 years. He states that he is fairly happy there however it is very isolated, unhappy to be living close by a railway line as this is disruptive. In receipt of ESA and two private pensions. He reports no financial concerns. He is close to his family, he has 2 children and they live in West Lothian. He states that he has contact with them on a daily basis via the telephone, however face to face contact is limited. He also told me that he has social contact via the telephone with a friend weekly. Most recently he states he is not leaving his flat. He is fearful of being attacked and he openly acknowledged that he feels very lonely at the present time.

Mr McRobb presented with good self care, he was clean shaven, smartly dressed in well laundered clothing. He was able to engage in the assessment. Prior to being seen he was observed to be sitting casually watching the television. There was no evidence of distraction. At assessment he stated that his mood was "empty" "scared". He was able to described obtaining pleasure from watching sports. Objectively he appeared relaxed and reactive. He gave an account of auditory hallucinations however from further discussion these appear to be the voices of neighbours whom he perceives are talking about him. At times he talked historically and this was a challenge and required clarification about his most recent difficulties. he states that he has broken sleep and obtains 3 hours sleep per night and his dietary intake is minimal. Mr McRobb spoke about his current difficulties at length however it became apparent that some of his difficulties were historical particularly in relation to auditory hallucinations. Subjectively he described himself as being very anxious and worried all the time. There was no suicidal intent voiced. No previous history known. He was keen to come into hospital.

Impression
60 year old male self presents complaining of having "an episode". Describes feeling he is psychotic. There was no evidence of

this at assessment however presents with social isolation and significant anxiety. He was able to engage and was reactive. He displayed forward planning, there was no suicidality voiced.

Formulation
Social anxiety and isolation.

Management Plan
1. Advised and encouraged to utilise the support available trough the Edinburgh Crisis Centre. he requested that I phone them through the professional line advising that he intended to call tomorrow, which I did.
2. Encouraged to keep his appointment with Dr Cooper on 19th April 2018 which he was in agreement with.
3. He is aware of the 24/7 nature of MHAS and was discharged.

Yours sincerely

Mhairi McLaughlin
MHAS Nurse Band 6

NHS Lothian

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Dr McKechanie
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 09/02/2018

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (60 years) 600086642R
Specialty	Adult Mental Health SW OPD	**Attendance Date**	05/02/2018
Consultant	Dr Deborah J Cooper		

Dear Dr McKechanie

Psychiatric Diagnoses:
1. Brief Psychotic Episode (currently resolving)
2. Harmful use of alcohol (currently abstinent)

Current Psychiatric Medication:
1. Olanzapine 10 mg (please note increased dose)
2. Temazepam 20 mg prn (suggest trying to stop)
3. Diazepam 5 mg prn (please limit supply)

I met with Mr McRobb following your 'urgent' referral on 5 February 2018 along with my attached medical student.

He described that he had three or four acute episodes, or what he calls attacks, over the past year or so. Reflecting, he feels these are usually triggered by very poor sleep. In relation to the last episode, he described several days of sleeping poorly and then one night of no sleep at all. Over the course of the following day he felt increasingly tense and edgy. He then described believing that people wanted to kill him and reported auditory hallucinations of multiple voices, stating how they could get into this house and what they would do to him when they did so. This caused him obvious distress and he ended up locking himself in the bathroom, arming himself with a kitchen knife. He had no intent of harming others but worries if someone had gained entry to his property that he might have lashed out in self defence. He reports that he called the Police, but did not answer the door when he attended this property the following day as he believed this to be a trick. There were no ideas of reference, passivity or hallucinations in other modalities.

After approximately forty-eight hours, he thinks he collapsed and fell into a sleep. After he woke up his symptoms gradually resolved. He can still feel slightly on edge and at times worries that conversations people are having are about him. However, he has insight into this and it does not seem to have reached a level where he truly believes this to be happening in recent days. Sleep is a chronic problem and he finds it difficult to switch off at night time. He describes feeling anxious (which is longstanding) particularly in public places or using public transport. He describes himself as depressed but there is no evidence of anhedonia or significantly poor motivation and this seemed to be a lesser problem at the current time.

Past Medical History:
Psoriasis

Personal History:
Mr McRobb reports he was born in Edinburgh but brought up in a children's home in North Berwick. This was run by Dr Barnardo's and he described it positively. He described some minor bullying at school, but it sounds as though he was robust in responding to this and these episodes were short lived. On leaving school he worked as a trawler fisherman, and then joined the Army. He was in the Army for eleven years, serving in Germany, Northern Ireland and brief periods abroad for training. He enjoyed his time in the

Army, feeling a sense of camaraderie. He saw some conflict related situations in Northern Ireland but did not seem to describe features clearly in keeping with Post Traumatic Stress Disorder.

Upon leaving the Army, he felt his mood dipped and he struggled to adjust to life in more typical work settings. By this point, he was married and his wife was pregnant with his second child. He began working in security doing shift work and unfortunately this pattern of working took a toll on his relationship with his wife and they split up in 1993. He has regular telephone contact with his children but sees them less frequently because of geography.

In terms of alcohol, he describes falling into a binge drinking culture when in the Army. This continued on leaving the Army and it sounds as though he would drink in a binge pattern twenty units per day. There was no clear withdrawal described, but he would describe having a hair of the dog. It was not clear he was drinking every day, but certainly a pattern well above recommended limits. He has had no alcohol since Christmas and has no urge to drink since. He stopped smoking prior to Christmas and does not misuse any illicit drugs.

Past Psychiatric History:
Mr McRobb himself reports approximately four similar episodes occurring in the past year. He had a period of care with the Intensive Home Treatment Team in the spring of 2017 when he was diagnosed with an acute psychotic episode. There is no other significant documented psychiatric history although he attends Veterans First Point. He started working with a psychologist and is very positive about this.

Mental State Examination:
At interview, Mr McRobb attended promptly and was warm and polite in manner. Eye contact was well maintained and speech was normal. Mood was reactive. There was no evidence of psychosis at interview and thoughts were ordered and logical. Cognition was not assessed and I think it would be worth assessing this at our next meeting.

Opinion:
Mr McRobb describes brief psychotic episodes occurring over the past year. His description would not be in keeping with a diagnosis of an underlying psychotic illness and I think the episodes link with poor sleep, previous heavy drinking with its possible impact on the brain and his time in the Army contributing to a sense of hypervigilance. However, I would be concerned about long term Diazepam use and think it would be worthwhile trying to optimise Olanzapine.

Plan:
1. I have suggested he increases Olanzapine to 10 mg.
2. He continues to attend Veterans First Point.
3. I will organise to see him in a couple of months.
4. I would suggest reviewing benzodiazepines once Olanzapine dose optimised.
5. I note he had a slight normocytic anaemia and wonder if it would be worthwhile completing a B12 and Folate. Please feel free to discuss.

Kind regards.

Yours sincerely

Dr Deborah Cooper
Consultant Psychiatrist

Cc William Kirkpatrick, Psychologist, Veterans First Point

PRIVATE AND CONFIDENTIAL

Veterans' F1rst Point Lothian
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Tel: 0131 220 9920

Date 22nd August 2017

Dr McKechanie
Springwell Medical Group
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Dear Dr McKechanie,

RE: Ronald McRobb, 8/5 Northcote Street, Edinburgh, EH11 2HL. D.o.B. 30.12.1957

I would be grateful if you could prescribe Mr McRobb 1mg of Risperidone to be taken twice daily. He was started on Olanzapine after a brief psychotic episode which has become non compliant within the community. He described it making him more "edgy" which is why he stopped taking it. I think given his history and ongoing symptoms access to an anti psychotic would make sense.

Veterans First Point is not always the best service for patients with experience of Psychosis and yet I note he is actively engaged with our Occupational Therapist and is on the waiting list for Psychological Therapy. I can see him in the future if there are concerns regarding his health. I do not intend to give him regular appointments to see myself.

Yours sincerely,

Dr Alex Quinn
Consultant Psychiatrist

cc Mr Ronald McRobb

PRIVATE AND CONFIDENTIAL

Veterans' F1rst Point Lothian
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Argyle House
3 Lady Lawson Street
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Tel: 0131 220 9920

Date 19th June 2017

Dr McKechanie
Springwell Medical Group
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Dear Dr McKechanie,

RE: Ronald McRobb, 8/5 Northcote Street, Edinburgh, EH11 2HL. D.o.B. 30.12.1957

I can confirm that Ronald attended for his assessment on 8th June 2017 following his registration appointment with Peer Support Worker Judith McClurg on 10th April 2017.

Diagnosis
Ronald appears to have a mixed anxiety and depression picture with avoidances and social isolation as well as binge drinking.

Presenting problems
Ronald told me he was in hospital a month ago with a mild psychotic experience and this was a reaction to the medication he was taking and mixing this with alcohol -.he is currently on 5mg of Olanzapine. He feels "paranoid" and thinks people are talking about him, doesn't go out on the street on his own, finds bus travel difficult and had taken a taxi to his assessment. Ronnie reported he had visited Dalry gym that morning. He feels anxious and is isolated - in his house he "feels like a prisoner". He was previously a big drinker who is trying to cut down, telling me that he had not drunk for two weeks. He has little contact with one friend who is married. Ronald rated his mood as 3 out of 10.

Current situation
Ronald is unemployed having last worked in August 2016 with Nairn's. He found this job monotonous and was eventually laid off. His children live in Bathgate, Lindsay who has two children of her own and Ross who has a child of his own. He saw them about a month ago and they are keen for Ronald to live closer to them.

Medication
Ronald takes Zopiclone at night and can sleep without this for 2-3 hours. He does have thoughts about harming himself with an overdose but more recently his family has become a protective factor.

Early history
Ronald lived in the Bardardos home in North Berwick from the age of 3-5 - he described it as a "good home" and they were well looked after – their younger sister was adopted . He did not know his mother and his father was a drinker who perhaps visited once. He has a twin brother whom Ronnie reported he only sees when his twin needs money.

Military history
Ronald served with the Royal Scots for 10 years after leaving the home at 18, and he made friends in the infantry. He did some clerical work and intelligence and trained as a dog handler. He was in Rifle Company as a Section Commander. He brought himself out as he was married at the time and his wife was pregnant and did not want to be stationed in Germany. He was deployed in Northern Ireland for two years - which he described as a good posting - and was based mainly in Edinburgh.

Other significant history
He was married whilst serving and based at Redford Barracks and their marriage broke up 4 or 5 years after leaving the Army. Alcohol was a constant for him throughout his service. He became disillusioned after the Army with work and civilian life, which he found mundane with no "adrenaline rush". He missed the structure he'd had both at home and in the Army and recognizes himself as institutionalized from childhood. He became depressed and thought after leaving in 1992 that "it was like a shutter had come down". He was previously employed in fishing and security.

Previous contact with services
Ronald has not received psychological therapy but has had some contact with alcohol services though not for some time now.

Impression
As I mentioned, Ronald has a mix of anxiety and depression fuelled by social isolation and avoidances probably partly in relation to his binge drinking. He reports some paranoid styles of thinking and I wonder if these are in the context of his alcohol use. He seems keen to change and wonders about moving to North Berwick where he enjoyed parts of his childhood but his children would like him to be close to them in West Lothian. Ronald was a man who displayed a degree of insight into how things have come to be for him however he does feel very limited by the sense of anxiety that he gets on leaving the house. He has hobbies that he can enjoy but he is struggling with these at the moment; fishing, history, cooking and reading. His continued abstinence from alcohol will be important in achieving any further plans.

Plan
1. I will refer him to Occupational Therapy for Individual Placement Support which is an employment focused piece of work.
2. I will also place him on the waiting list for psychological therapy.

19th June 2017

3. I will ask Psychiatry to review his medication.
4. I am going to refer him to Erskine's Shoulder to Shoulder project for a peer mentoring service.
5. I will also encourage him to attend drop in and invite him to do "worry time" where he will spend 10-15 minutes a day writing down his worries then work through the list. If he notices himself worrying about something during the day he can tell himself to worry about it later, not now. The goal of this is not to stop worrying but it is to change the way that he relates to the thoughts.

We will keep you updated as to our contact with your patient. Many thanks for your time on this matter.

Yours sincerely,

Charlie Allanson-Oddy
Consultant Psychological Therapist and Service Lead

Cc Ronald McRobb, 8/5 Northcote Street, Edinburgh, EH11 2HL

NHS Lothian

Royal Edinburgh Hospital

Dr McKechanie
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Edinburgh
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Date: 09/03/2017

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (59 years) 600086642R
Specialty **Consultant**	AMH Edinburgh - IHTT Donald Webster	**Attendance Date**	07/03/2017

Dear Dr McKechanie

Diagnosis & ICD-10:
Acute Psychotic Episode/F23
Harmful use of Alcohol/F10.1

Dates of admission & discharge:
20.02.17 - 07.03.17

DISCHARGE FORMULATION Risk formulation:
59 year old gentleman referred with concerns of acute psychotic episode secondary to sleep disturbance. Described period of insomnia which appears to have coincided with increase dose of Sertraline. Described hearing people talking about him in a threatening manner and beliefs that harm had come to his family.

Engaged well with IHTT staff and presented as suffering from social anxiety but did not present as preoccupied nor distracted at any time. He spoke of isolating himself recently whilst he finds it difficult to be in busy public spaces. Health also impacted due to binge drinking of alcohol. Although he complained of low mood he would converse well with staff, presented as reactive and euthymic.
He worried about people looking at him when outside or talking about him but this is not held with delusional intensity.

Staff advised him to reduce alcohol intake and continue to structure time and engage with friends and family. He was given information on Veterans 1st Point and has made contact with them. Provided with information on several other services including Health All Round and SAMH. He was keen to try to increase his activity levels and goes to a local gym regularly. He has hopes for the future to move back to North Berwick.

It was deemed unnecessary to refer to PCLT/CMHT follow up as his presentation changed markedly with acute episode resolving quickly with only anxiety symptoms remaining.

Risk Profile: No risk identified during IHTT contact, other than acute onset of psychosis which appears to have significantly lessened. No suicidal intent and no thoughts to harm self or others. Risk of deteriorating physical health in the context of alcohol excess.

Discharge medication:
1.Olanzapine 5mg NOCTE
2.Diazepam 5mg PRN max BD (not for repeat without review)
3.Zopiclone 7.5mg NOCTE

Further action/follow up:
Veterans 1st Point
GP

Completed by:
Donald Webster

Copies to:
GP

NHS Lothian

Royal Edinburgh Hospital
Morningside Place
Edinburgh
EH10 5HF

Dr McKechanie
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 22/02/2017

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (59 years) 600086642R
Specialty **Consultant**	AMH Edinburgh - IHTT Dr Rachel S Brown	**Attendance Date**	

Dear Dr McKechanie

I reviewed Mr McRobb at his home on 22.02.17 from 11am to 11.45am. He was referred to IHTT by Liaison Psychiatry yesterday with psychotic symptoms.

Briefly in his background Mr McRobb was born in Edinburgh but grew up in a children's home in North Berwick after his parents separated. He has never seen his mother but his father used to visit from time to time. His father had an alcohol problem. He has one brother who lives locally but has little contact with him. He met his sister around thirty years ago briefly after she made contact but has not seen her since. He reports a good life in the children's home with structure and routine. He enjoyed school with only occasional bullying but said her knew how to take care of himself. Upon leaving school he did a couple of jobs before joining the army where he was for twelve years and enjoyed it especially the regimented nature of it. He left after twelve years as he was being posted to Germany and his wife was pregnant with their second child and they did not see Germany as a good option for her. Mr McRobb has a son and a daughter (who has 3 children) who live in West Lothian. He is in regular telephone contact with them but only sees them infrequently citing his social anxiety as the reason he avoids public transport. He separated from his wife in 1993 after fourteen years of marriage saying they grew apart. She has since remarried. Since leaving the army Mr McRobb has had some different jobs, the last being at the Nairn oatcake factory from which he was made redundant last year.

Mr McRobb has had a problem with alcohol intake for decades starting with the army. He drinks beer and drinks in binges often to excess. He drinks at home on his own. He said that this year he has made a conscious effort to cut down but continues to binge. He recognises the harmful effect it has on his physical and mental health.

Mr McRobb reports feelings of anxiety and low mood since leaving the routine and order afforded by the army. He has struggled to settle into civilian life and often used alcohol to cope. He describes feelings of anxiety when outside the house and avoiding crowds. He restricts his movements to within his local area and to do what is needed. He reports feeling that people are talking about him and looking at him when he is out and about. These are not held with delusional intensity. He reports feeling low in mood on and off with good and bad days and with no diurnal variation. He does not have suicidal ideas. He reports generally eating well and looking after his self-care but says he has always had trouble sleeping. More recently he has been finding it hard to motivate himself and has neglected his hobbies and interests including music and watching documentaries. He has little contact with his friends.

With regard to his psychotic symptoms, these appear to have started after a period of insomnia of four nights following an increase in the dose of Sertraline. He began hearing people talking about him, threatening him harm and commenting on his actions. He had some ideas that his family were dead and he had been poisoned with ketamine darts on his knee but these have since resolved. He heard a voice again last night when he was putting the bin out talking about him. He denies any command hallucinations. There were no ideas of reference or any thought interference. He had no other delusional ideas.

On interview Mr McRobb was an overweight man with acne rosacia on his face. He was calm and reactive on interview with evidence of low mood. He was not suicidal and not actively psychotic. He had good insight.

Impression:
Mr McRobb appears to have suffered from an acute psychotic episode secondary to sleep disturbance. This is on a backdrop of longer-standing low mood and anxiety. He has not responded to anti-depressant medication to date. He drinks alcohol to excess. We agreed the following plan:

1.Stop Sertraline. Continue Olanzapine 5mg NOCTE and use Diazepam 5mg PRN BD for anxiety in the short-term.
2.Mr McRobb to keep his appointment with Health in Mind for guided self-help.
3.We will refer Mr McRobb to the South East PCLT for psychological management of his anxiety and low mood.
4.Refer to IHTT OT for help with activity and structure.
5.Advised to abstain from alcohol.
6.Provide information on South East Recovery Hub for alcohol support.
7.Short-term IHTT contact over the next week to ten days to enable these referrals to take place.
8.Home visit tomorrow at 2pm. Can change the time as needed (has a GP appointment between 10 - 11am tomorrow).

Yours sincerely

Dr Ihsan Kader
Consultant Psychiatrist

NHS Lothian

Royal Edinburgh Hospital

Dr McKechanie
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 21/02/2017

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (59 years) 600086642R
Specialty	AMH Edinburgh - IHTT	**Attendance Date**	20/02/2017
Consultant	Dr Rachel S Brown		

Dear Dr McKechanie

This patient has been taken on by the Intensive Home Treatment Team as an alternative to hospital admission.

Please note we will prescribe psychotropic medication whilst the patient is under our care and will send you a discharge summary when our episode of care has ended.

Please call the team on 0131 537 6851 if you wish to discuss any aspect of your patient's care.

Yours sincerely,

Julie McGregor
Medical Secretary

NHS Lothian

Lauriston Building
Lauriston Building
Lauriston Place
Edinburgh
EH3 9HA

Dr McKechanie
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 21/12/2015

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (57 years) 600086642R
Specialty **Consultant**	Dermatology Prof JL Rees	**Attendance Date**	08/12/2015

Dear Dr McKechanie

Phototherapy Discharge Letter

Diagnosis: Psoriasis
Treatment: Narrow band UVB twice weekly to whole body
Number of Treatments: 27
Start Date: 04.08.15
End Date: 08.12.15
Result: Minimal residual activity
Residual Sites: Lower legs
Adverse Effects: None
Comment: Did not attend the last 3 treatments
Treatment on Discharge: Exorex lotion, Trimovate ointment
Follow-Up: Discharged to GP

Yours sincerely

J Carter
Phototherapy Enrolled Nurse

NHS Lothian

Lauriston Building
Lauriston Building
Lauriston Place
Edinburgh
EH3 9HA

Dr Liddle
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 12/11/2013

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (55 years) 600086642R
Specialty **Consultant**	Dermatology Prof JL Rees	**Attendance Date**	07/11/2013

Dear Dr Liddle

Phototherapy Discharge Letter

Diagnosis: Psoriasis

Treatment:: Narrowband UVB (2 x week)

Number of treatments: 29

Start date: 24.06.13

End date: 8.11.13

Outcome: Minimal residual activity

Residual sites: Small area Lower right leg.

Adverse effects: None

Treatment on discharge from phototherapy:
Using Exorex to small area where plaque is palpable Doublebase gel to moisturise body and limbs, Aveeno to face.

Follow-up: GP

Yours sincerely

Staff Nurse M McBride
Phototherapy Nurse

NHS Lothian

Lauriston Building
Lauriston Building
Lauriston Place
Edinburgh
EH3 9HA

Dr Ali
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 24/05/2013

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (55 years) 600086642R
Specialty **Consultant**	Dermatology Dr Caroline S Murray	**Attendance Date**	13/05/2013

Dear Dr Ali

DIAGNOSIS:
Psoriasis

SUGGESTED TREATMENT:
E45 wash
Aveeno cream twice daily
Eumovate ointment 1 application twice daily for 5-7 days to face and ears then twice weekly
To continue 5% coal tar solution

Thank you for referring this 55 year old man to Clinic. He has had psoriasis for 2 years and it fluctuates. I note his other medical history of depression and I don't think his psoriasis has helped, as he is less inclined to go out and is very embarrassed about the condition of his skin.

On examination this gentleman had extensive thin plaque psoriasis. I note a dark mole on the right lower back, which bore no sinister features or dermatoscopy and which, as far as this gentleman is concerned, has not changed and is long-standing. I photographed this for our records.

I have put this gentleman on the waiting list for phototherapy. In the meantime I have just made a couple of tweaks to his treatment, as detailed above most importantly I have asked him to stop using Elocon to his face. I am hoping we will get him clear with his phototherapy and, if this is the case, that he will get a remission for a fair while.

Best wishes

Yours sincerely

DR CAROLINE MURRAY
Consultant Dermatologist

CSM/kmd/Dictated 13/5/13

NHS Lothian

Western General Hospital
Outpatient Department
Lower Ground Floor
Anne Ferguson Building
Crewe Road South
Edinburgh EH4 2XU

Dr Ali
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 24/04/2013

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (55 years) 600086642R
Specialty **Consultant**	General Surgery Medinet Mr Misra Rai Budhoo	**Attendance Date**	13/04/2013

Dear Dr Ali

OUR REF: MRB/LWDATE TYPED 15/04/13
.
Thank you for asking me to see this gentleman who has had recurrent peri-anal warts. I understand he has had this problem before and this was treated surgically.

Examination confirms the diagnosis.

He would like to have these removed and I will make arrangements for him to come in, in due course, as a day case.

Yours sincerely

Mr Misra Rai Budhoo
General Surgeon
MEDINET

University Hospitals Division

Western General Hospital
Outpatient Department
Lower Ground Floor
Anne Ferguson Building
Crewe Road South
Edinburgh EH4 2XU

NHS Lothian

Dr Ali
Springwell Medical Group
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Date First Created	15/04/2013
Date Authorised	24/04/2013
Date/Time Printed	01/05/2013 14:14
Our Ref	600086642R
CHI	3012571450

Patient:	Mr Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**UHPI:**	600086642R
		Date of Birth:	30/12/1957
Clinic Code:	MRB Medinet Sat	**Attendance Date:**	13/04/2013
Specialty:	General Surgery Medinet		
Consultant:	Mr Misra Rai Budhoo		

Dear Dr Ali,

OUR REF: MRB/LW DATE TYPED 15/04/13

Thank you for asking me to see this gentleman who has had recurrent peri-anal warts. I understand he has had this problem before and this was treated surgically.

Examination confirms the diagnosis.

He would like to have these removed and I will make arrangements for him to come in, in due course, as a day case.

Yours sincerely

Mr Misra Rai Budhoo
General Surgeon
MEDINET

Outpatient Clinic Letter

NHS Lothian

Royal Infirmary of Edinburgh
Outpatient Department 2
51 Little France Crescent
Edinburgh
EH16 4SA

Dr Liddle
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 22/02/2012

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (54 years) 600086642R
Specialty **Consultant**	Endocrine Prof B Walker	**Attendance Date**	17/02/2012

Dear Dr Liddle

Diagnosis:
Mild hypogonadotrophic hypogonadism
Previous alcohol excess and depression
Psoriasis

He has felt pretty well since starting Testogel 50 mg daily. With more energy he has been taking more exercise, including jogging and cycling, and has lost some weight. He has had some adverse effects of some sore joints, insomnia and headaches, but these have worn off.

I have checked bloods concerning potential adverse effects of testosterone and will let him know if there is a problem.

Now that he has lost weight, his endogenous testosterone may well have risen. I have suggested that he completes the current course of Testogel and then tries without for a month or so. He will come back to you for a further prescription if he feels it's really necessary.

I have given him a backstop appointment for next year.

Yours sincerely

Brian R Walker
Professor of Endocrinology
Clinical Secretary: 0131 242 1481
Appt. Enquiries: 0131 242 1368/1369
Typed by: djh

NHS Lothian

Royal Infirmary of Edinburgh
Outpatient Department 2
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Edinburgh
EH16 4SA

Dr Cavaghan
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 11/11/2011

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (53 years) 600086642R
Specialty **Consultant**	Endocrine Dr AJ Jaap	**Attendance Date**	02/11/2011

Dear Dr Cavaghan

DIAGNOSIS:
Borderline hypogonadism
Depression
Previous alcohol excess
Psoriasis

CURRENT MEDICATION:
To commence Testogel one sachet daily

I reviewed your patient today in the Endocrine Clinic. MR pituitary was arranged at the previous visit although his testosterone was not particularly low; the pituitary was normal. There is no other evidence of any other pituitary hormone deficiency. His testosterone had been slightly low on more than one occasion and he complained of symptoms which may be due to hypogonadism - namely depression and erectile dysfunction. He understands, however, that these symptoms are very difficult to pin down to any particular cause and that a trial of testosterone replacement would be the only practical way of finding out whether this low testosterone is causing him any problems. We discussed the different replacement options and he is keen to try a gel in the first instance. He does have fairly bad psoriasis and understands he needs to avoid any areas of active psoriasis when applying the gels and that if he experiences any skin irritation he ought to let us know so that he can be switched to IM replacement. I also advised him to avoid using any creams or lotions in the areas of skin he is applying the Testogel.

We discussed the effects of testosterone on the prostate and the need for monitoring his PSA and full blood count. These were both normal today with PSA 1.3 and haemoglobin 145.

We arranged for him to return in 2 months' time. For completeness we should check his ferritin at his next visit.

Yours sincerely

Dr SCOTT MacKENZIE
Honorary Specialist Registrar

NHS Lothian

Royal Infirmary of Edinburgh
Outpatient Department 2
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Edinburgh
EH16 4SA

Dr Cavaghan
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 23/09/2011

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (53 years) 600086642R
Specialty	Endocrine	**Attendance Date**	14/09/2011
Consultant	Dr AJ Jaap		

Dear Dr Cavaghan

Mr McRobb's full blood count is satisfactory with a haemoglobin of 139, a white cell count of 8.1 and platelets of 316. His urea and electrolytes are also within normal limits and calcium is 2.44 with an adjusted calcium of 2.36. A baseline cortisol level is 259 rising to 544 after 30 minutes post Synacthen which is a normal response. His TSH is 0.99 with a free T4 of 12. I will forward the result of his MRI scan of pituitary which is currently outstanding.

Yours sincerely

Dr ANN LOCKMAN
Specialist Registrar
Secretary: 0131 242 1479/1480/1481
Appt. Enquiries: 0131 242 1368
Typed by: fec

NHS Lothian

Royal Infirmary of Edinburgh
Outpatient Department 2
51 Little France Crescent
Edinburgh
EH16 4SA

Dr Cavaghan
Springwell Medical Group
Springwell Medical Centre
39 Ardmillan Terrace
Edinburgh
EH11 2JL

Date: 21/09/2011

Outpatient Clinic Letter

Patient	Ronald McRobb 8/5 Northcote Street Edinburgh EH11 2HL	**CHI** **Date of Birth / Age** **UHPI**	**3012571450** 30/12/1957 (53 years) 600086642R
Specialty **Consultant**	Endocrine Dr AJ Jaap	**Attendance Date**	14/09/2011

Dear Dr Cavaghan

Thank you for referring this 53 year old man with a testosterone of 9.3 and calculated free testosterone of 164. As you know, he has had erectile dysfunction for 2 years. Recently this is accompanied by a feeling of tiredness, feeling rundown and just absolutely has "no energy". He has a history of depression and he attributed his symptoms to depression previously but now he is feeling that there is something else is going on as the symptoms have become persistent. Past medical history includes psoriasis, warts, broken nose and traumatic injury to his fingers. He is not on any medication at the moment. Previously he was on antidepressants in 1997, which were discontinued due to side effects. He lives alone and works in security. He drinks about 12 units of alcohol/week. Previously he drank a lot of alcohol, at least 18 units/day for 2 days/week. He has stopped drinking heavily in the last 2 years. There is no family history of diabetes or hypertension. He has not noticed any change in shaving frequency. He has not noticed any gynecomastia. However, he did notice an increase in weight recently and central obesity.

O examination, he has central obesity with psoriasis widespread. Chest is clear and cardiovascular system is unremarkable. Abdomen was soft and nontender and liver edge is palpable. External genitalia is normal. His testicles are present on both sides with a volume of 20 ml. There is no other evidence to suggest a pituitary mass. Visual field on direct confrontation is within normal limits.

I have arranged for him to have a full pituitary screen including synacthen test. I have arranged for repeat testosterone and calculated free testosterone this morning. MRI scan of pituitary has also been arranged to exclude structural cause of his hypogonadotrophic hypogonadism. We will review him again in clinic once all these results are available in 2 months' time and I have sent what I hope is a suitable appointment for him.

Yours sincerely

Dr Anne Lockman
Specialist Registrar
Clinical Secretaries: 0131 242 1481/1480/1479
Appt. Enquiries: 0131 242 1368/1369
Typed by: djh