

Aims. Treatments without robust evidence are not recommended. However, some patients detained in secure hospitals might need novel approaches such as: off-license use of medication, use of psychological (rather than their biological) effects of drugs. In addition, some detained patients may request for unconventional treatments they believe in. In community and capacitous patients, the clinician's role is advisory and the burden is on the patient to make the final decision and access such treatments privately. However, in a detained patient (with or without capacity), it may fall on the Responsible Clinician (RC) to deny or facilitate access to such interventions. Currently, there is no guidance for such circumstances. We have presented three real cases followed by proposing a flowchart to guide RCs.

Methods.

Case 1 (2019–2020): X with mild Learning Disability (LD) and mixed personality disorder detained under Section 3 with no leave to community. X asked for Hypericum which has been helpful with her headaches in the past. X had capacity to make that decision.

Case 2 (1996–97): Y with mild LD and aggressive behaviours responding instantly to any injection. Y lacked capacity so injections of distilled water was tried in his best interest, with equal positive effect. The question was about using distilled water as rapid tranquilisation with no side effects.

Case 3 (2020–21): Z with a treatment-resistant psychosis who has been unwell for months and detained in four different PICUs. Z's father requested N Acetyl Cysteine which had historical calming and sedative effects for Z.

Results. The main issue in case 1 is the conflict between the patient's Human Rights and RC's Duty of care. Here the patient could be potentially deprived of their right to make an 'unwise decision' should the RC bar her access to a treatment which lacks evidence but is privately available to public. This can be construed as an infringement of Article 8 of Human Rights.

The issue in case 2 and 3 is rather different. Here the conflict is between the RC's duty of care to provide evidence-based treatments and the patient's "best interest" which seems to be an intervention without robust evidence.

Conclusion. We have developed a flowchart to help RCs by navigating amongst several competing/ conflicting legal and ethical concepts such as: Patient's wish/Human rights, Patient's capacity, Bolam test, "Medical Treatment" Under Section 63, 62 or 58 of Mental Health Act 1983, Best interest, Second Opinion (SOAD) and advice from court.

The Various Faces of Creutzfeldt-Jakob Disease (CJD); a Case of CJD Presenting as Psychosis in a Middle-Aged Woman

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Aims. Creutzfeldt-Jakob disease (CJD) is a rare, progressive, fatal neurodegenerative disorder caused by an abnormal glycoprotein known as the prion protein. The core features include progressive cognitive decline, cerebellar dysfunction, personality changes, and visual disturbances. Although psychiatric symptoms are rare, they can be the primary symptom of CJD, and such presentations can pose diagnostic difficulties. In this paper, we describe the case of

Ms. R, who manifested psychotic symptoms as the first signs of CJD.

Methods. Ms. R, was a 49-year-old white British female not previously known to psychiatric services, who presented with acute onset of florid psychotic symptoms. Her symptoms included auditory hallucinations, paranoia, and thought disorder. She was treated with antipsychotics for over four weeks, following her admission, but no improvement was seen. Instead, her psychosis worsened with cognitive decline, mutism, and the appearance of neurological symptoms such as jerky body movement, ataxia, and falls. All screening blood tests, chest X-ray, and CT abdomen were normal. The MRI, however revealed few patches of high T2/FLAIR signal in the deep white matter. Cerebrospinal fluid showed increased protein. Neurologist reviews suggested the possibility of sporadic CJD (sCJD) as a probable diagnosis. As her condition deteriorated, she became comatose and died four months after the appearance of the first psychiatric symptoms.

Results. It can be challenging to diagnose CJD since the clinical picture overlaps with other neuropsychiatric and neurodegenerative conditions. It requires the presence of relevant clinical findings along with positive CSF, EEG, or MRI findings to make a probable diagnosis. Regarding our case, some noteworthy observations were psychosis as the initial symptom, relatively delayed onset of neurological signs, rapid deterioration with brief duration of illness. The MRI findings were typical of those seen in sCJD, although the EEG did not suggest sCJD. A differential of variant CJD was considered because of her age, prominent psychiatric symptoms, and delayed neurological signs.

Conclusion. Creutzfeldt-Jakob disease course is rapidly progressive, and majority of patients die within one year. Therefore, awareness of early clinical features is of great significance. Among other things, this would enable patients and their families time to understand the nature of CJD, prognosis and prepare advanced directives. This case adds to the growing number of atypical presentation of CJD as well as pointing to an expanding spectrum of the disease. Therefore, clinicians should consider CJD in the differential diagnosis of new-onset psychosis, particularly if symptoms persist and worsen despite standard psychiatric treatment.

Patient Initiated Follow-Up (PIFU) Within Adult Secondary Care Mental Health Services

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Aims. The traditional 'one size fits all' model within secondary care mental health (MH) settings of regular appointments scheduled by a clinician at defined intervals isn't always responsive to an individual's changing needs. Previous reviews have shown significant levels of patient and clinician satisfaction with Patient initiated models of review in a variety of healthcare settings but its use within secondary care MH settings has been relatively limited. We describe the development and implementation of a Patient initiated follow-up (PIFU) pathway within MH services in NHS Greater Glasgow and Clyde (GG&C).

Methods. The pathway was developed by a small working group of clinicians with input from local management and eHealth colleagues with an emphasis on the principles of Realistic Medicine. There was input from peer support workers and the Mental Health network, a local service user organisation, into the development of the pathway. The pathway underwent a 'test of

implementation' within three adult CMHT's with support from the development group. Feedback from the test sites was used to modify the pathway and ultimately support the wider rollout of the model across all seventeen CMHTs within NHS GG&C over the course of 2021. Formal evaluation of the pathway, including patient and clinician satisfaction, service utilisation as well as safety measures, is due to be undertaken at 12 months after full implementation.

Results. The tests of implementation identified a range of factors that needed to be considered as part of the introduction of a PIFU model into MH settings.

Patient choice and shared decision making along with other clinical factors such as level of insight, availability of other supports, shared risk assessments and current clinical need were identified as relevant patient related factors. Clinician related factors included concerns about applicability within MH settings, perception of risk, increase in workload and appropriate identification of suitable patients. Regular meetings between the clinicians in the test sites and members of the development group as part of the implementation process helped address clinicians concerns and ultimately supported uptake of the model.

Conclusion. Our experience highlighted the potential for a personalised approach to care planning in empowering patients have a more active role in the way they access services as part of their recovery journey. It also highlighted patient and clinician related factors that need to be considered for a successful adoption of the model.

Use of Pseudoephedrine in the Management of Severe Clozapine Induced Urinary Urgency and Frequency

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Aims. Clozapine has several effects on the genitourinary system including enuresis and an overactive bladder (OAB). However, little if any has been written about its effect in causing OAB and its prevalence. Typical feature of OAB is urinary urgency associated with urinary frequency in the absence of urinary tract infection or other obvious pathology. Having 8 voids or more in 24 hours in addition to urinary urgency is strongly suggestive of OAB. AB developed AOB while being treated with clozapine.

Methods. AB is 33 years old white lady with a well-established diagnosis of emotionally unstable personality disorder. She has been in mental health services from her late teens. She has had a trial of several antipsychotics, both oral and depot and has had a number of DBT sessions and one EMDR with limited effect. Prior to this episode, AB has had two successful trials of clozapine, one resulting in her longest period (9 months) of living in the community in 1998.

AB was started on clozapine again in 2021, she developed urinary frequency. She requested it to be stopped. Her condition deteriorated such that she needed intensive care unit. AB was again started on clozapine. She developed urinary frequency once more when the dose reached 250 mg. She did not have infection. For one week, her urinary frequency ranged from 36–66 in 24 hours. It was more evident in the day time. There was no incontinence. AB remained in her room close to her toilet. She stopped engaging in her therapy, she did not mix with others and did go out. She tried a number of medications-aripiprazole, oxybutynin and desmopressin with no benefit. Pseudoephedrine was started at 15 mg twice a day, eventually reaching 30 mg

three times a day. Within two weeks, the urge disappeared and the frequency normalised. Six months on, AB remains well and has not reported any side effects.

Results. Pseudoephedrine, an indirect alpha-adrenergic agonist successfully normalised AB's urinary frequency. It was evident so within few days though the maximum benefit was noted within two weeks. This is in agreement with what is reported in cases with enuresis

Conclusion. Very little is known about clozapine induced OAB. It had a severe negative impact on AB, who failed to engage in her therapy and her social life. Pseudoephedrine brought relief within a short period of time. In case of OAB and when stopping clozapine is not an option because of underlying severe mental disorder; think of pseudoephedrine.

The Impact of Stigma on Forensic Psychiatric Patients - a Case Report

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Aims. The Royal College of Psychiatrists' Fair Deal (RCPsych 2008) highlighted the far-reaching impact of stigma and discrimination on the lives of people with mental illness. The pervading nature of stigma has been acknowledged in recent national and international mental health policies (WHO). The World Health Organisation reiterates people affected by mental illness should not suffer social exclusion and marginalisation due to stigma.

Methods. A sixty-year-old gentleman presented to the Emergency Department following self-inflicted stabbing to the neck resulting in pharyngeal tear and surgical repair. Previous psychiatric history included inpatient admission on Section 2 following a major depressive episode. On this admission, inpatient psychiatric review elicited three months of psychotropic medication non-adherence due to difficulties the patient had encountered in acquiring repeat medications from his GP. He had relapsed into alcohol misuse as a coping mechanism culminating in a suicide attempt at home with a knife. Upon recommencing of sertraline and risperidone during admission, he was assessed as euthymic with low risk to self. The patient had been previously abstinent from alcohol and described religion as a protective factor. Prior to discharge, the patient's GP stated he must present to the surgery in person with a form of identification. This is despite CQC guidance stipulating practices should not refuse patients registration if proof of identity cannot be produced.

Results. This case illustrates the socioeconomic factors increasing likelihood of suicide including forensic history, low financial status, unstable housing and lack of social support. Substance dependence is a risk factor that can be reduced by supporting patients in accessing specialist misuse input from inpatient and community teams. The patient reported fear of stigmatisation and criminalisation which led to the avoidance of seeking treatment, deterioration in mental health and severe clinical consequences. It is imperative marginalised patients with mental illness can access quality health care and this starts with GP registration.

Conclusion. Forensic mental health patients experience multiple stigmas impacting on well-being including social, institutional and media stigmatisation and high levels of internalised stigma. The Time to Change campaign focused on changing attitudes and behaviour however evaluation illustrated difficulties in tackling this issue. Healthcare professionals should be mindful to avoid stigmatising language and actions to ensure fairness in care. There is a