[1]Cumbria, Northumberland, Tyne and Wear Foundation NHS Trust, Newcastle, United Kingdom; [2]Coventry and Warwickshire Partnership NHS Trust, Coventry, United Kingdom and [3]Leicester Partnership NHS Trust, Leicester, United Kingdom

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Aims: Internally displaced persons (IDPs) in Nigeria experience numerous challenges, including psychological distress resulting from displacement and trauma. In October 2024, a cohort of volunteer mental health professionals based in the United Kingdom provided sessions of mental health support via virtual means to displaced women in Abuja, Nigeria. This intervention utilised telemedicine to address barriers to access and adhered to the principles of Psychological First Aid (PFA).
Methods: The initiative required significant pre-event coordination. Mental health professionals from local and international backgrounds were recruited to volunteer, and a structured counselling protocol was developed. Zoom conferencing was utilised to conduct the sessions, with efforts made to incorporate trauma-informed approaches. Despite thorough planning, technical difficulties arose, including unreliable Wi-Fi connections that intermittently disrupted sessions. Power outages were also problematic, necessitating the use of generators at the Nigerian location to maintain a supportive environment. During the sessions, participants disclosed accounts of hardship and trauma. Volunteers emphasised active listening, empathy, and cultural sensitivity to establish trust and provide meaningful support.
Results: Collaboration played a pivotal role in the success of this initiative, showcasing its critical contribution to the field of mental health care. The collaboration between local and international mental health professionals underscored the strength of teamwork. Each volunteer's dedication, despite the challenges, contributed to the overall impact of the project. The shared responsibility among the team fostered a supportive network that bolstered resilience against challenges, which is key in mental health-care provision. Feedback from participants and volunteers reflected the success of the initiative, with attendees expressing gratitude and an openness to future mental health interventions.
Conclusion: This initiative demonstrated the power of perseverance, creativity, and collaborative efforts in delivering psychosocial support to underserved populations. By adopting a flexible approach and prioritising the needs of the participants, the event successfully bridged gaps in care and provided a platform for displaced women to be heard and supported. Future initiatives can build upon these findings, enhancing technological resilience and refining to ensure greater reach to those most in need.

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Hypomanic Switch Induced by Lurasidone: A Case Report

Dr Fatma Sena Ozbal[1] and Dr Baxi Sinha[2]

[1]Tees, Esk and Wear Valleys NHS Foundation Trust, Middlesbrough, United Kingdom and [2]Tees, Esk and Wear Valleys NHS Foundation Trust, Stockton-On-Tees, United Kingdom

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Aims: Bipolar Affective Disorder (BAD) is known to present with manic or hypomanic episodes, along with depressive episodes occurring at different times. Considerable within-normal-range mood variations between episodes are expected. In some cases, mania or hypomania can be induced by medications. While well-established medications such as corticosteroids and levodopa are known to induce mania, a careful examination of possible triggers for manic switches is essential to ensure individualized patient care.
Methods: This 34-year-old Caucasian female patient presented with depressive disorder. She has a history of multiple depressive episodes. She had been on sertraline for seven months for her most recent depressive episode. However, due to excessive sweating as a reported side effect, her medication was switched to fluoxetine at 20 mg daily, which was subsequently increased to 40 mg after three weeks. On the fifth day after the dose increase, she presented with hypomanic symptoms, changing her diagnosis to Bipolar Affective Disorder (BAD), current episode hypomania. Fluoxetine was identified as the causative agent for this switch. However, at the patient's request, fluoxetine was continued with antipsychotic and/or mood stabilizer cover, as the patient retained the capacity to make decisions regarding her medical management. The patient was otherwise fit and well, with no recent drug or alcohol involvement. She was prescribed lorazepam 0.5 mg PRN QDS, zopiclone 7.5 mg PRN nightly, and risperidone 1 mg BD in addition to fluoxetine 40 mg daily. Due to drowsiness associated with risperidone, she was commenced on lithium PR titration. Two weeks later, her subsequent symptoms were consistent with mixed affective states. The fluoxetine was discontinued with the patient's consent. Lurasidone 37 mg was initiated alongside lithium (Priadel XL) 600 mg. Four days after the medication change, the patient reported feeling sedated and experiencing low energy levels. After this review, her lithium dose was increased to 800 mg. Eight days after initiating lurasidone, the patient called the clinic with marked irritability. She reported having high energy levels and feeling very well. The review revealed another hypomanic switch with marked rapid speech and reduced need for sleep. The symptoms of hypomania have resolved following discontinuation of lurasidone.
Results: This case report highlights the possible hypomanic switch associated with the use of lurasidone. With several new drugs approved for mental illnesses including BAD, it is crucial to monitor their side-effect profiles to ensure safer and more effective management.
Conclusion: There are several potential confounders identified in this case.

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Case Study: Aphonia in Psychosis: Bridging ENT and Psychiatry

Dr Akansha Tewari[1], Dr Andrea Pathak[2], Dr Ashish Pathak[2] and Dr Abhinav Tewari[1]

[1]Dr. Ram Manohar Lohia Institute of Medical Sciences (RMLIMS), Lucknow, India and [2]Essex Partnership University NHS Foundation Trust (EPUT), Basildon, United Kingdom

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Aims: Aphonia, defined as partial or complete loss of voice, can have multifactorial origin, ranging from organic to functional aetiology. This paper aims to describe an unusual presentation of aphonia on the background of psychotic symptoms and catatonia.
Methods: Mr KC, a 23-year-old mechanic presented to an outpatient ENT (Otorhinolaryngology) clinic at a tertiary care hospital in North

India. As per available information, KC was asymptomatic until 1 month ago. Over the next week, the family members observed KC to be withdrawn, quieter than usual and skipped work. He would reluctantly accept food and eat less than usual. Family members consulted general practitioners who advised multivitamins and supportive measures, with no improvements in KC's symptoms.

In the week preceding hospital visit, family members got concerned as KC would spend an entire day without speaking. He would occasionally nod yes/no or utter 1–2 words at his own will. He clenched his jaws when family attempted to feed him. Family googled KC's symptoms and guided by the suggestions over the internet, they decided to visit the ENT clinic for further evaluation.

Upon presentation to the clinic, KC appeared dishevelled and had clearly lost weight, with his clothes hanging loosely. He refused cooperation for the oral and laryngoscopic examination. Neurological examination revealed increased rigidity in both limbs following which a psychiatry referral was done and a provisional diagnosis of catatonia was established.

After a lorazepam challenge, the rigidity reduced, and KC became more compliant, accepting small amounts of food. The laryngoscopy was performed when KC was cooperative, revealing no structural abnormalities or any pathological finding. His speech returned, and he expressed fear, saying, "I can hear people plotting against me". With a diagnosis of psychosis, oral risperidone 4 mg per day (divided dose) was started. Routine blood tests revealed nutritional deficiencies likely due to prolonged food refusal. Two weeks into the treatment, KC resumed normal interaction, and his speech was fully restored.

Results: The case highlights the collaborative approach of ENT and mental health professionals in prompt identification and treatment of aphonia. Unlike many patients who present to ENT clinics with aphonia due to stress-related causes, this case is unique because psychotic symptoms overlapped with the aphonic presentation.

Conclusion: This case emphasizes the importance of a multidisciplinary approach in the diagnosis and management of aphonia. It serves as a reminder to consider a broader differential diagnosis when encountering aphonia, particularly in patients with unusual behavioural changes or neurological signs.

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Kaleidoscope in the Mind: Charles Bonnet Syndrome

Dr Joel Philip and Dr Feena Sebastian

Essex Partnership University NHS Foundation Trust, Wickford, United Kingdom

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Aims: Charles Bonnet syndrome (CBS) is a phenomenon characterized by complex visual hallucinations in visually challenged patients. CBS may go unrecognized and be misdiagnosed as early dementia or psychosis.

Methods: We present the case of an 83-year-old Caucasian gentleman 'X' who was referred to the older adult home treatment team.

X reported that his problems began when some men turned up at his door a few weeks earlier, regarding an application he had made to the council for solar panels. X suffered from a complex delusional framework, believing that these men have stayed around in his home and are living in his loft. He believed that there are microphones in his bedroom and that his conversations are being transmitted to malicious people who work for the council.

X reported distressing visual hallucinations of men in his kitchen threatening him with guns. Other hallucinations included his ex-partner engaging in sexual activities with the aforementioned men, which led him to believe that she has been forced into the sex trade. He reported seeing distorted faces in his bathroom mirror, bodies floating up against the ceiling, and children with metallic prostheses for limbs. X recently received a diagnosis of a mild cognitive impairment following a referral made by the GP to the memory clinic. Prior to this, he did not have a history of psychiatric or neurological illness.

Interestingly, X had previously undergone excision of his right eyeball for the treatment of cancer, and has a skin graft at the site. He has only partial vision in his remaining eye due to macular degeneration.

Results: Three criteria should be fulfilled to diagnose CBS; namely, visual loss, clearly formed recurrent visual hallucinations, and insight into the unreal nature of the hallucinations.

In our case study, X fulfilled the first 2 criteria, but was unable to appreciate that the images that he sees are not real. We surmise that X may initially have understood that his hallucinations are not real, but these hallucinations gradually became amalgamated with his delusional belief systems, leading to a loss of insight.

Conclusion: CBS should be considered as a diagnostic possibility in persons with visual impairment presenting with visual hallucinations, and differentiated from psychotic and neurological disorders such as dementia, delirium and late-onset psychosis.

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SLC6A1 Neurodevelopmental Disorder: A Case Report

Dr Nikita Pillay, Dr Gurjot Brar and Dr Niamh Mulryan

AVISTA, Dublin, Ireland

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Aims: Solute Carrier Family 6 member 1 (SLC6A1) genetic mutations are rare and mostly reported in the paediatric population. Few reports on adult cases have been mentioned in the literature. At present only pathological and likely pathological variants can confirm a diagnosis of SLC6A1-related neurodevelopmental disorder.

Methods: We report the clinical presentation of an adult male with a heterozygous variant of uncertain significance of the SLC6A1 gene. He presented with developmental delay initially and only in later years presented with other features in keeping with SLC6A1-related neurodevelopmental disorder. This includes moderate intellectual disability, epilepsy, autism, attention deficit disorder, behavioural difficulties including aggression. A further EEG at age 14 also showed focal and general abnormalities, however an MRI was normal. He was trialled on methylphenidate, lis-dexamphetamine and atomoxetine which were all unsuccessful. In 2024, genetic testing revealed a heterozygous variant of uncertain significance of the SLC6A1 gene.

Results: Our case adds further credence to the growing literature on SLC6A1 gene-related disorder and SLC6A1-related neurodevelopmental disorder. This individual illustrates the diverse clinical phenotype. Given the lack of published evidence, the result from