Methods. Mr AB was admitted last year with profound self-neglect. He was detained under Section 2MHA as he wasn't eating and drinking and wasn't engaging with services. With the initial diagnosis being Recurrent Depressive Disorder, AB was commenced on treatment for the same and eventually received ECT, for which he had strongly opposed. Following 6 sessions of ECT, AB bargained with the team that he would start eating and drinking if ECT was stopped and did so as well. He then requested a transfer to a different ward and consultant, with whom he shared that he doesn't agree with our diagnosis of depression or Schizoid personality disorder. AB expressed that he doesn't find his life worth living and wants to be left alone. He strongly believed that his liberty to take decisions about his life is being unfairly taken away by the NHS and accused professionals of trying to protect themselves. No evidence of SMI found at this stage. Following several discussions, AB was discharged home. He however was readmitted within a couple of days' time by his brother following disengagement, self-neglect and again, no evidence of SMI.
Results. A capacitous patient, in the absence of Serious Mental Illness puts forth an argument that purely because his way of living and his opinions on life and death differ from that of the society, doesn't mean that his rights over his life can be taken away from him. He, however, struggles to acknowledge that as fellow humans we are strongly inclined to intervene and try to stop anyone from taking their own life.
Conclusion. A Challenging case that raises several questions surrounding Medical Ethics. The team is now looking into guardianship to ensure welfare of the patient.

Legal Parameters of Practice in Psychiatry

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Aims. The amended Mental Health Act (MHA) of 2007 gave Psychiatrists the right to detain, assess and treat individuals with mental health disorders, not only with a view to offer medical treatment but also to ensure their safety and that of the public, by containing them. This meant that patients diagnosed with disorders such as Antisocial Personality (APD), previously un-detainable under the MHA of 1983, would no longer be considered untreatable and could be sectioned, if appropriate. The idea was then generated, that Psychiatrists would now assume the role of custodians of potentially dangerous people and raised the concern that all persons with APD would be perceived as dangerous and find themselves at a dynamic risk of being sectioned under the revised MHA. The balance between the role of Psychiatrists as medical professionals versus this new, unpopular role as figures of public order was and still is, debatable.
Methods. We present the case of a patient with a background of Depression and Post-traumatic Stress Disorder with aggressive features, who during a consultation revealed a powerful homicidal urge and fantasies directed to an individual he believed had wronged him. The patient had access to the individual and had attempted to confront him. He had no forensic history, nor had he expressed criminal intent before. This triggered a safeguarding response, the consensus being that advice should be sought from the Forensics team, not only to protect the potential victim but also the potential perpetrator from the consequences of a criminal act.
Results. Considering the lack of police involvement, plans, or weapons; the separation between patient and potential victim; and the patient's distress associated with the disclosure of the homicidal fantasies, the level of risk was deemed to not merit disclosure. Closer risk assessment with ongoing psychological and pharmacological interventions created a therapeutic alliance which allowed for open communication with regards to the dynamic nature of the risk and the potential for any further disclosure.
Conclusion. Within the definition of Duty of Care lie responsibilities beyond the strictly medical role of clinicians. Not unlike the duty to inform the DVLA about a patient's fitness to drive, breaking confidentiality for the purposes of patient or public safety is not a power that makes Psychiatrists figures of Authority, but a responsibility that is part of their role. At the same time, we should bear in mind that the license to disclose is also a license not to disclose.

Key Learning Points from a Case of Cannabinoid Induced Catatonia

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Aims. Catatonia has an effective treatment: benzodiazepines. A first presentation of catatonia may present initially to an acute medical trust. It is important acute clinicians are familiar with its manifestations, medical differentials, and most importantly, understand the role of benzodiazepines in both the investigation and management of catatonia.
Methods. Here we describe a case of catatonia in a nineteen-year-old male, who presented acutely to the accident and emergency department with odd behaviour following inhalation of the synthetic cannabinoid 'spice'. Initially, he was found to be rigid, mute and doubly incontinent, but able to follow vague commands. He was admitted to the acute trust for twelve days in which he was worked-up as a case of drug induced psychosis. As he was not improving, he was then transferred to psychiatric inpatient services for further investigation and management.
Results. The acute medical team did not recognise this as a presentation of catatonia and did not conduct a lorazepam challenge, as suggested by specialist services. A lorazepam challenge is helpful in both diagnosing and treating catatonia. In this case, we believe this may have been missed, due to a lack of knowledge and understanding of the condition. Medical mimics of psychosis, such as autoimmune encephalitis, may be life threatening, but have a good prognosis if treated early. Here, these were not considered, which may have led to disastrous consequences had they been present. This case shows an opportunity for education into the differentials and management of catatonia.
Conclusion. We believe this case highlights a degree of poor understanding surrounding catatonia and its clinical work-up in the acute setting. There were missed opportunities to instigate treatment earlier and consider rarer alternative causes for the presentation. We hope this case will simplify diagnosis and management for acute clinicians, and highlight important medical mimics of catatonia. This case also shows the potential significant harms of synthetic cannabinoids such as 'spice' and highlights a

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