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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doi: 10.1192/bjo.2022.369

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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doi: 10.1192/bjo.2022.370

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