Conclusion. 22q11.2 Duplication Syndrome is a rare genetic syndrome that can cause learning disability. Its physical and behavioural phenotypic features described in literature, were all present in this patient. In addition, this case report highlights three previously unreported findings: Cochlear Nerve Atresia, Tubular Vision, the Characteristic groove and skin fold on the back of the scalp and the presence of a schizoaffective mental illness.

A Tale of Two Catatonic States

Dr Harleen Kaur Birgi[1]*, Dr Geoff Lawrence-Smith[2] and Dr Simon Kirwin[2]

[1]North East London NHS Foundation Trust, London, United Kingdom and [2]East London NHS Foundation Trust, London, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.337

Aims. Catatonia is a psychomotor state characterised by a multitude of clinical signs such as abnormal movements, mutism and withdrawal. This condition is usually associated with medical and psychiatric aetiologies with potential of being life-threatening. It is usually managed with benzodiazepines, the commonest being lorazepam. In this piece of work, we would like to focus on the principles of care that should be considered whilst managing such presentations.
Methods. Case 1- 71, male with diagnosis of paranoid schizophrenia was brought to Emergency department (ED) via ambulance, as he was found 'unresponsive' in care home. On arrival, he was alert with GCS 11/15 and was observed to be mute, 'gesturing' and making purposeless movements. Following our assessment, he was administered 0.5mg of lorazepam whilst in resuscitation bay. Subsequently, he started making sounds and was given another dose of 0.5mg lorazepam. He then vocalised his thoughts and we established that his mental state had relapsed and he was harbouring paranoid delusions.

Case 2- 18, male with no prior psychiatric history was brought to ED by his parents following 3 day history of being mute, not 'responding', not eating or drinking and insomnia. On arrival, he was alert, pacing in the room, however remained mute. Following our assessment, he was given a 2 mg dose of lorazepam whilst in resuscitation bay as the initial 1mg showed minimal response. On later review, he was smiling, conversant and co-operative, thus allowing assessment of his unmasked mental state which was suggestive of first episode psychosis.

Following few hours, both patients reverted back to their original catatonic state.
Results. Lorazepam can be used as a diagnostic measure in conjunction to a therapeutic intervention. A positive Lorazepam Challenge test confirms the diagnosis of catatonia. It must be borne in mind that Lorazepam is only used as a temporary holding measure to assess patient's unmasked mental state and they would need further monitoring and interventions to treat the underlying cause.
Conclusion. Lorazepam Challenge test can be safely used as an assessment technique for patients presenting in acute catatonia. This should be conducted in closely monitored environments namely, resuscitation bay, HDU or ITU with appropriate support and ongoing liaison with psychiatry team. Treating teams should be mindful of various patient characteristics including age, past treatment with benzodiazepines, psychiatric history to inform dose adjustments as necessary.

Disclaimer: Unable to obtain patient consent due to unstable mental state but ensured minimal patient identifiable data included.

Schizotypal Disorder With Borderline Personality Traits: A Case Report

Dr Rakesh Byra Reddy* and Dr Surabhi Hullumane

Black Country Healthcare NHS Foundation Trust, Dudley, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.338

Aims. Schizotypal disorder is characterized by pervasive patterns of odd behavior, appearance, or thinking. There is also a high degree of overlap in symptoms between schizotypal and borderline personality disorders. The following case describes a case of schizotypal disorder with borderline traits.
Methods. 25-year-old female presented with history of mood fluctuations with recent low mood, anxiety and an ability to read other people's thoughts. She was admitted to hospital 4 years ago and was diagnosed with emotionally unstable personality disorder (EUPD) and mixed anxiety and depression.

She reported anxiety to leave the house due to referential and persecutory ideas, odd beliefs of being able to read people's minds and predict future. She lacked friends and also had fear of abandonment. There was intermittent impulsive self-harm behavior and reportedly harmed herself indirectly through casual sex in the past and also had two failed relationships. She denied illicit drug use. Childhood was uneventful, except that schooling was difficult due to anxiety. She was treated on Quetiapine, Fluoxetine and Promethazine. Further assessments confirmed added features of unusual perceptions, smelling things, superstitious ideas regarding colours and magical thinking. Dissociative episodes of her being a devil, expressing thoughts of slitting her throat were present.

As there was minimal improvement, Aripiprazole was tried. She had poor compliance with Aripiprazole due to the belief that it was poison. She herself requested depot injection, which was started. There has since been mild improvement in her paranoia, but social anxiety is persistent. Psychoeducation about the diagnosis was challenging, after which she accepted referral for psychotherapy.
Results. The initial diagnosis of EUPD was inconsistent with other features like ideas of reference, strange beliefs, magical thinking, abnormal perceptions and social anxiety. On further assessments, a diagnostic clarification of schizotypal disorder was considered. This poses challenge in diagnosis and therapeutic approach due to the overlap of symptoms. Cognitive-perceptual distortions and affective symptoms of EUPD appear to overlap with disorganized and cognitive-perceptual symptoms of schizotypal disorder. Historically, borderline was separated from schizotypal personality disorder from an entity called borderline schizophrenia.
Conclusion. Schizotypal disorder is rarely seen as the primary reason for treatment in a clinical setting and can be misdiagnosed. The presence of co-morbid personality disorder traits can be challenging for the management decisions. It also has an impact on

the individual and family for acceptance of the diagnosis and compliance to treatment.

The Cheshire and Merseyside Tier 4 CAMHS Gateway Model: A Case Study on the Implementation of a Clinician-Led New Care Model to Respond to the Needs of Children and Young People at Risk of Admission to Tier 4 CAMHS or Receiving Inpatient Mental Health Care. the Model Addresses Established System Challenges, Has Developed Multi-Agency Tools and Has Reduced the Need for Escalation Beyond Professionals at Place; Has Had an Impact on Avoidable Admissions to In-Patient Settings; and Has Informed System Learning Concerning the Interface Between Research, Policy, and Practice

Ms Elizabeth Collins[1,2*] and Dr Fiona Pender[2,1]

[1]Level Up Provider Collaborative, Cheshire and Merseyside, United Kingdom and [2]Cheshire & Wirral Partnership NHS Trust, Chester, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.339

Aims. Young people with moderate to severe mental health needs receive community services and/or referral to Child and Adolescent Mental Health Services (CAMHS). The NHS Long Term Plan acknowledges the importance of age-appropriate care for young people and, where needs are complex or severe, Tier 4 CAMHS specialist support may be considered. Whilst inpatient support is appropriate and helpful on occasion, research reflects potential risks and challenges (Cotgrove and Northover, 2021): The Gateway Programme is a multi-agency approach for professionals to provide consistent evidence-base and recommendations where young people's moderate to severe mental health difficulties combine with risk factors, including Tier 4 admission.
Methods. Working with multi-agency stakeholders, a tool was developed for commissioning, clinical, social care, education professionals, providing consistent, evidence-based approach to:

- articulating current presenting difficulties
- formulation
- safeguarding concerns
- actions
- legal frameworks
- confirmation of actions, contingency planning, timescales.
- This is the SBAR Tool (Situation, Background, Assessment, Recommendations).
- Gateway Meetings are a multi-agency model for Cheshire and Merseyside, to discuss SBARs and meet needs of young people with moderate to severe mental health difficulties or elevated risk of self-harm and suicide with:
- risk of admission to/awaiting discharge from Tier 4 CAMHS
- discharge from paediatric wards delayed
- risk of care placement breakdown or custody.

Results.

- Programme support for implementation, development and evaluation funded by Beyond Children and Young People's Transformation Programme
- Since February 2022, 8 of 9 Local Authority Places established Gateway Meetings, with the Gateway Programme Team supporting the ninth
- During this period, 67 Gateway Meetings reviewed 138 SBARs via multi-agency discussion. This reduced the requirement for escalation beyond teams at Place: unmet needs of children and young people are being addressed via discussion at Gateway. Connections between this activity and reduction in avoidable admissions are being explored
- Gateway webpages and Community of Practice launched in 2022, sharing learning across teams and organisations.

Conclusion. Gateway stakeholder focus groups are co-producing evaluation reviewing:

- outcomes for young people & their needs
- avoidable admission/length of stay at Tier 4/A&E presentation/ paediatric ward bed days
- stakeholder relationships/use of resource.

Meanwhile, learning from the Gateway Model has included recognition of the complexity of implementation where interface between research, policy and practice is coherently explored in multi-agency settings.

In response, online material concerning Gateway will be complemented with recorded resources for professional learning during 2023, featuring clinicians, Local Authority colleagues and experts by experience, to further support busy professionals across different learning styles, to understand and engage with the model.

Ventriculomegaly in Mania - a Possible Neural Correlate?

Dr Galina Lisa D'Souza*, Dr Avinash Joe, Dr Pavithra P Rao and Dr Aruna Yadiyal

Father Muller Medical College, Mangalore, India
*Corresponding author.

doi: 10.1192/bjo.2023.340

Aims. Bipolar disorder is one of the most common psychiatric illness, however the neurophysiologic basis remains unknown. Lateral ventriculomegaly is a well-recognized finding in bipolar disorder. Multiple-episode patients exhibited significantly greater ventricular volumes than first-episode patients. Traumatic brain injury is also an independent risk factor for the development of mania.We present to you a case where a patient with mania had the above mentioned risk factor and finding.
Methods. 40 year old married lady hailing from a rural nuclear family presented with decreased sleep, increased talk, increased activity, elevated mood and overfamiliarity since 1 month. On further interviewing patient was found to have sustained mild head injury around 8 months ago .MRI study of the brain revealed mild lateral and third ventriculomegaly.A diagnosis of organic mania with a differential of mania with psychotic symptoms was made.
Results. Ventriculomegaly in bipolar disorder has been reported but not in mania alone-its occurrence at illness onset or progression remains unclear. There is no literature on the prognostic value of the finding. Ventriculomegaly in our patient was found incidentally on MRI whether the finding was present prior to the head injury or is a post head injury change is unclear. There are studies which indicate development of posttraumatic