Schizophrenia are however lacking. Trance and Possession Disorders defined by the ICD-10 refers to a group of disorders involving temporary loss of both the sense of personal identity and full awareness of the surrounding with individuals acting in some cases as if taken over by another personality, spirit, deity, or force with reports of such states occurring in primary psychotic disorder. This case presentation describes a 22-year-old male whose first episode of schizophrenia was preceded by moral injury
Methods. A 22-year-old male Nigerian with a strong conservative Christian religious upbringing and a history of receiving a prophecy against having intercourse with women. He started showing symptoms of a mental illness a month after attaining coitarche with a lady. This presentation was characterized by irrelevant speech, intrusive flashbacks and unusual beliefs (excessive guilt, ill health). 7 months after, he was presented to the hospital with above symptoms and disorganized behavior characterized by beliefs of being possessed by four different people, shouting in different voice textures, throwing himself on the floor. We kept in view a diagnosis of schizophrenia and placed him on oral Olanzapine 5mg nocte following which he made significant improvement within 2 weeks with no memory of the event.
Results. Different factors can be considered in the aetiopathogenesis and presentation of symptoms in this patient. According to Williamson V. et. al; An Individual's experience of moral injury may lead to feelings of shame or guilt which was present in this patient (delusion of guilt). The pathogenic effect of culture and religion(e.g through prophecy against intercourse with women) may account for this illness. Moreso, pathoplastic and pathoreactive effects of culture could be said to have contributed significantly to the presentation of a psychotic disorder with trance and possession state as a reaction to moral injury.
Conclusion. Moral Injury, not previously considered to be associated with primary psychotic disorder may not only possibly precipitate a primary psychotic disorder but also show cultural/religious differences in phenomenology.

Further studies are therefore required to explore these associations.

A Case Study to Explore Safe Psychotropic Medication(s) for a Patient Suffering From Priapism

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Aims. A 53-year-old male was admitted with non-resolving Priapism for 36 hours and was reviewed for advice regarding his psychotropic medications. He previously took Viagra about 2 days ago, and had an erection which resolved spontaneously. He underwent penile aspiration in the hospital which provided relief. Following that, he developed signs of infection which was treated with IV antibiotics. He was then waiting for further surgical correction.
Methods. He has a background history of psychotic illness and been treated with Quetiapine, Mirtazapine, Sertraline and Zopiclone, which were kept on hold during his admission. He reported that he currently suffers from depression and signs of psychosis, which take the form of auditory hallucinations and paranoid delusions.

He has been taking Viagra occasionally for years, but has not experienced side-effects like this before. He is a social drinker and previously smoked cannabis.
Results. From the above scenario, there appears to be two clinical questions:

1. Are the current medications responsible for his priapism?
2. What medication(s) would be a suitable alternative if his priapism was indeed caused by his current drug regimen?

The major causes of Priapism are: direct trauma; haematological diseases; neurological diseases; cerebrovascular diseases; Medications; TPN and Neoplasm. Apart from medication side-effects, these other causes were ruled out.

The Summary of Product Characteristics for mirtazapine, sertraline, quetiapine and zopiclone were studied for their relative risk of causing priapism, and this is summarised below:

- Mirtazapine: unknown
- Sertraline: rare
- Quetiapine: rare
- Zopiclone: not listed

However, a paper by Salonia et al found that all the above medications except Zopiclone can increase the risk of priapism. Internationally published case reports also list priapism-associated medications as: risperidone; quetiapine; sildenafil; mirtazapine; citalopram; chlorpromazine and olanzapine.

Anti-psychotics cause priapism by Alpha-1 blockade and anticholinergic actions. Most of the antipsychotics have anticholinergic action. The medication which demonstrates the least alpha-1 blockade is Amisulpride which acts by blocking dopaminergic receptors in the brain.
Conclusion. Thus, it is clear from the above discussion that Amisulpride has the least possibility to cause Priapism. The patient was advised to take low dose Amisulpride and afterwards, no other complications were noted.

Atomoxetine as an Alternative Therapy for Adolescent Adhd With Comorbid Cerebral Palsy: A Case Report

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Aims. The prevalence of Attention Deficit Hyperactivity Disorder (ADHD) in children with Cerebral Palsy (CP) is 19%. Whilst there is evidence that methylphenidate is an efficacious first line therapy for patients with ADHD, there is a lack of literature describing atomoxetine use in ADHD with comorbid CP.
Methods. Here we report the case of a 17-year old Caucasian female with ADHD and CP. The patient was referred to Child and Adolescent Mental Health Services (CAMHS) for ongoing anxiety following extensive orthopaedic surgery, which was managed with sertraline and concurrent Cognitive Behavioural Therapy.

A CAMHS assessment led to her subsequent diagnosis of ADHD resulting in an initial treatment of low-dose methylphenidate (Ritalin). This was discontinued after four days due to

progressive headache, tachycardia, and unilateral leg restlessness. The patient was hesitant to commence lisdexamfetamine, a second line stimulant medication, due to the possibility of similar adverse side effects.

Atomoxetine (20mg/day) was commenced for a month then increased to 30mg/day. After five months, it was discontinued. The patient reported no significant improvements to attention or concentration, but reported a later onset of escalating anxiety prior to discontinuation. Consultation revealed that the patient's anxiety may be attributed to biopsychosocial factors unrelated to pharmacotherapy, but could not discount the possibility that this was a side effect of atomoxetine. Following the discontinuation of atomoxetine, the patient and her carer were amenable to trialling lisdexamfetamine.

Results. Previous data have demonstrated that patients with CP have lower tolerance to particular pharmacological agents, therefore atomoxetine was started at a low dose (20mg/day) to permit a gradual titration up to the recommended therapeutic dose. Worsening anxiety whilst on atomoxetine (30mg/day) may be a result of one or a combination of the following: (1) long-term side effect, (2) subtherapeutic dose response, (3) identified precipitating and perpetuating psychosocial factors, particularly in the school setting.

Conclusion. The case report demonstrated an acceptable safety profile for the use of atomoxetine in a young person with ADHD and comorbid CP. The expected therapeutic benefits of atomoxetine for ADHD may have been offset by extenuating biopsychosocial factors. Further research is needed to determine whether there exists a causal relationship between atomoxetine therapy and worsened anxiety within this patient group. Furthermore, this case highlights the importance of understanding the complexities of ADHD treatment in patients with confounding environmental factors and comorbid neurological disorders.

Service Evaluation

Improving the Admission Process to Inpatient Wards for Gender Diverse Service Users at Oxleas NHS Foundation Trust: Service Evaluation

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Aims.

1. To evaluate the knowledge and experience of staff members working in inpatient units at Oxleas NHS trust on the topic of healthcare of gender diverse service users.
2. To improve the admission process for gender diverse service users by creating an admission checklist, increase awareness and provide training when possible.

Methods. A questionnaire with 11 questions was sent to different staff member groups. The questions assessed their knowledge of the policies for gender diverse service users and their clinical experience in dealing with this group of service users when being admitted to inpatient wards.

Results. 25 members of staff completed the questionnaire. Of those, 52% were not aware of the existence of a specific policy for admitting and treating gender diverse service users at Oxleas. From the respondents who knew about the policy, 60% did not know where to find it. 44% of all respondents do not ask service users for their preferred name, gender and pronouns when they are admitted to an inpatient ward. From those who ask service users, 45% do not document service users' chosen name, pronouns and gender identity on RiO (the digital record system used at Oxleas). 68% of participants do not know how to change the demographics information on RiO for service users. When asked about the allocation criteria for inpatient beds, 24% replied that it should be done according to the service user's assigned gender at birth, while 8% responded that they should be allocated to any available bed. 40% of staff members reported that trans service users can not easily access daily personal products on the ward that are related to their trans-specific health needs. 72% of those who responded do not know what specific services or organisations to direct this group of service users to in case they need any further support. 56% of staff do not feel confident in dealing with trans specific needs and 88% have not received any training on the area from the Trust.

Conclusion. Although the Trust has created a specific policy for gender diverse service users, staff members' knowledge of such policy is sub-optimal. Moreover, there is a lack of training available to staff on inpatient wards, which is reflected in their lack of confidence in working with this group and the lack of knowledge around external services to refer these service users to. In response to this, we have implemented some changes. Pronoun preference has been added to RiO and we have encouraged staff members to use it when completing demographics. An admission checklist specific to gender diverse service users was created and shared within the organisation. We scheduled teaching sessions on this topic, however, these did not go forward due to lack of attendance.

Outcome Measures at Discharge From a Local Early Intervention in Psychosis Team

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Aims. Review of the outcomes from a local EIP service, in terms of symptom control employment status at referral and discharge, admissions whilst under the care of the service physical health status at discharge, discharge was back to primary care or secondary care

Methods. Sample of service users discharged from EIP services over the past 2 years between March 2020 and March 2022 was collated

Results.

Recovery

Good proportion -84% had good symptomatic recovery at time of discharge based on discharge letter

Discharge to primary care

Low proportion -Only 26% were discharged onwards to secondary mental health services such as recovery teams or community mental health teams and rehabilitation services.

74% discharged to primary care

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