Aims. Treatments without robust evidence are not recommended. However, some patients detained in secure hospitals might need novel approaches such as: off-license use of medication, use of psychological (rather than their biological) effects of drugs. In addition, some detained patients may request for unconventional treatments they believe in. In community and capacitous patients, the clinician's role is advisory and the burden is on the patient to make the final decision and access such treatments privately. However, in a detained patient (with or without capacity), it may fall on the Responsible Clinician (RC) to deny or facilitate access to such interventions. Currently, there is no guidance for such circumstances. We have presented three real cases followed by proposing a flowchart to guide RCs.
Methods.
Case 1 (2019–2020): X with mild Learning Disability (LD) and mixed personality disorder detained under Section 3 with no leave to community. X asked for Hypericum which has been helpful with her headaches in the past. X had capacity to make that decision.
Case 2 (1996–97): Y with mild LD and aggressive behaviours responding instantly to any injection. Y lacked capacity so injections of distilled water was tried in his best interest, with equal positive effect. The question was about using distilled water as rapid tranquilisation with no side effects.
Case 3 (2020–21): Z with a treatment-resistant psychosis who has been unwell for months and detained in four different PICUs. Z's father requested N Acetyl Cysteine which had historical calming and sedative effects for Z.
Results. The main issue in case 1 is the conflict between the patient's Human Rights and RC's Duty of care. Here the patient could be potentially deprived of their right to make an 'unwise decision' should the RC bar her access to a treatment which lacks evidence but is privately available to public. This can be construed as an infringement of Article 8 of Human Rights.

The issue in case 2 and 3 is rather different. Here the conflict is between the RC's duty of care to provide evidence-based treatments and the patient's "best interest" which seems to be an intervention without robust evidence.
Conclusion. We have developed a flowchart to help RCs by navigating amongst several competing/ conflicting legal and ethical concepts such as: Patient's wish/Human rights, Patient's capacity, Bolam test, "Medical Treatment" Under Section 63, 62 or 58 of Mental Health Act 1983, Best interest, Second Opinion (SOAD) and advice from court.

The Various Faces of Creutzfeldt-Jakob Disease (CJD); a Case of CJD Presenting as Psychosis in a Middle-Aged Woman

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doi: 10.1192/bjo.2022.367

Aims. Creutzfeldt-Jakob disease (CJD) is a rare, progressive, fatal neurodegenerative disorder caused by an abnormal glycoprotein known as the prion protein. The core features include progressive cognitive decline, cerebellar dysfunction, personality changes, and visual disturbances. Although psychiatric symptoms are rare, they can be the primary symptom of CJD, and such presentations can pose diagnostic difficulties. In this paper, we describe the case of Ms. R, who manifested psychotic symptoms as the first signs of CJD.
Methods. Ms. R, was a 49-year-old white British female not previously known to psychiatric services, who presented with acute onset of florid psychotic symptoms. Her symptoms included auditory hallucinations, paranoia, and thought disorder. She was treated with antipsychotics for over four weeks, following her admission, but no improvement was seen. Instead, her psychosis worsened with cognitive decline, mutism, and the appearance of neurological symptoms such as jerky body movement, ataxia, and falls. All screening blood tests, chest X-ray, and CT abdomen were normal. The MRI, however revealed few patches of high T2/FLAIR signal in the deep white matter. Cerebrospinal fluid showed increased protein. Neurologist reviews suggested the possibility of sporadic CJD (sCJD) as a probable diagnosis. As her condition deteriorated, she became comatose and died four months after the appearance of the first psychiatric symptoms.
Results. It can be challenging to diagnose CJD since the clinical picture overlaps with other neuropsychiatric and neurodegenerative conditions. It requires the presence of relevant clinical findings along with positive CSF, EEG, or MRI findings to make a probable diagnosis. Regarding our case, some noteworthy observations were psychosis as the initial symptom, relatively delayed onset of neurological signs, rapid deterioration with brief duration of illness. The MRI findings were typical of those seen in sCJD, although the EEG did not suggest sCJD. A differential of variant CJD was considered because of her age, prominent psychiatric symptoms, and delayed neurological signs.
Conclusion. Creutzfeldt-Jakob disease course is rapidly progressive, and majority of patients die within one year. Therefore, awareness of early clinical features is of great significance. Among other things, this would enable patients and their families time to understand the nature of CJD, prognosis and prepare advanced directives. This case adds to the growing number of atypical presentation of CJD as well as pointing to an expanding spectrum of the disease. Therefore, clinicians should consider CJD in the differential diagnosis of new-onset psychosis, particularly if symptoms persist and worsen despite standard psychiatric treatment.

Patient Initiated Follow-Up (PIFU) Within Adult Secondary Care Mental Health Services

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doi: 10.1192/bjo.2022.368

Aims. The traditional 'one size fits all' model within secondary care mental health (MH) settings of regular appointments scheduled by a clinician at defined intervals isn't always responsive to an individual's changing needs. Previous reviews have shown significant levels of patient and clinician satisfaction with Patient initiated models of review in a variety of healthcare settings but its use within secondary care MH settings has been relatively limited. We describe the development and implementation of a Patient initiated follow-up (PIFU) pathway within MH services in NHS Greater Glasgow and Clyde (GG&C).
Methods. The pathway was developed by a small working group of clinicians with input from local management and eHealth colleagues with an emphasis on the principles of Realistic Medicine. There was input from peer support workers and the Mental Health network, a local service user organisation, into the development of the pathway. The pathway underwent a 'test of