with epilepsy: we queried temporal lobe, and a functional psychotic illness. We advised for a medication review, and his levetiracetam was reduced to a prior dose and lamotrigine was added on by the epilepsy clinic.
Conclusion: Two months after the presentation we received a letter from his paediatrician mentioning his psychiatric symptoms have improved and the add-on medication managed to control his seizure.

Case Report: The Injectable Contraceptive as a Contributing Factor to Mental State In a Young Female With Autism Spectrum Disorder and Intellectual Disability

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Aims: This case study explores the psychiatric and physical health complexities in a 28-year-old female service user with Autism Spectrum Disorder (ASD) and Intellectual Disability, focusing on the interplay between neuropsychiatric diagnoses, hormonal treatments, and significant mental health deterioration. It also examines the impact of hormonal changes on mood and behaviour, highlighting potential misdiagnosis of emotional instability versus neurodevelopmental conditions. The service user has a history of polycystic ovary syndrome (PCOS), irritable bowel syndrome, and Benign Rolandic Epilepsy (seizure-free since age 13). She has engaged with mental health services since adolescence, carrying multiple diagnoses including generalized anxiety disorder, post-traumatic stress disorder and emotionally unstable personality disorder (EUPD). Her mental health worsened suddenly and significantly following a switch from an oral progesterone contraceptive to the Depo-Provera injection, prompting inpatient psychiatric care.
Methods: A thorough medical and psychiatric evaluation was conducted during the nine-month inpatient admission. This included a mental state examination, routine blood tests, CT head imaging, and extensive collateral history collection. Medication adjustments were made including trials of SNRI and SSRI medication, and multidisciplinary therapeutic interventions were provided. Her Depo-Provera was not re-administered. Her PCOS diagnosis was confirmed and she was started on metformin. A diagnosis of ASD was implemented seven months into the admission and her EUPD diagnosis removed. Her depressive and anxious symptoms were noted to be cyclical, worsening before her menstruation. Following MDT review, she was started on an oral contraceptive with good evidence in pre-menstrual syndrome and PCOS (estradiol with nomegestrol)
Results: The service user presented with severe depression, anxiety, and active suicidal ideation, including multiple attempts to leave the ward to act on her plans. Initial physical and neurological workups were unremarkable. The pre-admission switch to Depo-Provera was identified as a likely contributing factor to her deterioration, as no other psychosocial triggers were found. She was subsequently detained under the Mental Health Act due to ongoing suicidality. Despite intensive psychiatric and therapeutic interventions, her mood remained persistently low – however after initiating an appropriate contraceptive, her symptoms showed some stabilization. Her risk of self-harm persisted.
Conclusion: This case highlights the potential influence of hormonal changes on psychiatric symptoms in women with complex neurodevelopmental disorders such as ASD. It also raises important considerations about the potential misdiagnosis of personality disorders in neurodivergent individuals and the need for careful management of hormonal treatments in this population. Further research into the hormonal impact on mood disorders in neurodivergent patients is warranted.

ADHD and Substance Misuse in the Club Drug Clinic: A Case Series

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Aims: Attention Deficit Hyperactivity Disorder (ADHD) has a well-established link with substance misuse, with growing evidence that individuals with ADHD are at higher risk of developing addictive behaviours including substance use disorders.

The Club Drug Clinic is a specialised addiction service providing support for individuals experiencing problems related to the use of club drugs. During assessments and reviews, patients presenting with symptoms suggestive of ADHD are formally assessed. Those who are diagnosed with ADHD are then commenced on appropriate treatment.
Methods: 15 out of 98 patients (15%) under the service since July 2023 were diagnosed with ADHD by the Club Drug Clinic, all of whom were subsequently commenced on atomoxetine.

Data was collected from patient notes including: age, gender, sexuality and information about their substance misuse. The doses of atomoxetine prescribed as well as side-effects and perceived benefits was also recorded. Information around co-morbid mental illness was also analysed.
Results: 87% of patients in this series were male with the majority of patients reporting their sexuality as either homosexual or bisexual which is reflective of the population group served generally by the Club Drug Clinic. The age range of the patients was 24–58 with an average age of 40.

Crystal Methamphetamine was the most frequently used illicit drug with 70% of those diagnosed with ADHD using Crystal Meth in an either a harmful or dependent manner. 60% of those with ADHD were using GHB often in conjunction with Crystal Meth. 50% of those identified in this study were using ketamine.

47% of patients commenced on atomoxetine reported side-effects and 33% of patients commenced on atomoxetine stopped due to side-effects or a lack of perceived benefit.

Depression was the most common co-morbidity in those diagnosed with ADHD seen in 20% of this cohort. Other co-morbidities include: anxiety disorder, borderline personality disorder, bipolar affective disorder and interestingly gaming disorder.
Conclusion: This series reflects the strong association between ADHD and addiction particularly within the Club Drug Clinic population. Implications include routine screening for ADHD in

Club Drug users to help identify cases early and potentially reduce long-term substance misuse. It also highlights the importance of integrated mental health services given the high rates of co-morbidity in patients suffering from addiction.

A Case of Very Late Onset Schizophrenia-Like Psychosis Presenting in a Patient Forty Years Post Acoustic Neuroma Resection

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Aims: Very late onset schizophrenia-like psychosis (VLOSLP) can be defined as individuals presenting with symptoms of psychosis after the age of 60 that cannot be attributed to an "affective disorder or focal or progressive structural brain abnormality". Despite being described by an international group consensus in 1998, this diagnosis is not included in ICD–11 or DSM–5 manuals.
Methods: A 79-year-old female presented with a 3-month history of auditory hallucinations, involving 10 voices talking in the 2nd and 3rd person and providing commands. The patient also described visual, tactile and olfactory hallucinations.

The patient did not have any previous psychiatric history. Significant past medical history included previous surgical removal of right-sided acoustic neuroma resulting in facial nerve palsy.

On assessment, there was right-sided facial paralysis, deafness and slurred speech. The patient was calm and well kempt. Speech and mood were normal. There was no formal thought disorder and the patient was not responding to unseen stimuli. They were orientated to time, person and place. The patient displayed insight into their mental state.

CT head showed mild small vessel disease. The patient scored 79/100 (attention 17/18, memory 16/26, fluency 8/14, language 23/26, visuospatial 15/16) on the Addenbrooke's cognitive examination, whilst psychotic and without hearing aids in situ.

The patient was started on aripiprazole, titrated to a dose of 20 mg. Fewer voices were heard and became incredibly faint, with there being some days where she was unable to hear them. The patient had not been experiencing hallucinations at 3 months post-discharge.
Results: There have been some case reports of acoustic neuromas presenting with psychiatric symptoms such as hallucinations and persecutory delusions and emerging post resection.

Individuals with hearing impairment are significantly more likely to develop psychosis. Hearing impairment is a modifiable risk factor for developing dementia and individuals with VLOSLP display an increased risk of developing dementia. It has been postulated whether VLOSLP could be a prodrome for dementia. The mainstay of treatment for VLOSLP involves low dose atypical antipsychotics.
Conclusion: We describe a case of VLOSLP in a patient 40 years post acoustic neuroma removal. There needs to be further work to investigate neuropsychiatric presentations post acoustic neuroma removal. There is increasing evidence to suggest an association between hearing impairment and development of psychosis and dementia. Any hearing impairment should be treated promptly. Patients with VLOSLP should be monitored for the development of dementia given it could be a prodrome for dementia.

A Double-edged Sword: Balancing the Benefits and Risks of Clozapine

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Aims: Clozapine is recommended for treatment-resistant schizophrenia after two other antipsychotics have failed. We discuss a case of clozapine toxicity on therapeutic dose and its complications due to multifactorial causes.
Methods: 60 years Caucasian female, diagnosed with Paranoid Schizophrenia in the early 80s and on clozapine since 2000. Her mental health had been stable since and she was on 375 mg/day. There were some residual symptoms but otherwise functioning well with support. She was admitted to General Hospital with pneumonia, weight loss and altered bowel habits but nil sinister found. Her clozapine was missed for 72 hours and she developed rebound psychosis. Clozapine was re-titrated to 300 mg/day as her clozapine levels were 720 mcg/L before admission. She was discharged on the 300 mg/day however she was readmitted to General Hospital within a few months after sustaining a fracture of the femur and underwent surgery. Clozapine assays showed high levels of 1882 mcg/L with MR 2.68. She had ongoing symptoms suggestive of delirium. She was investigated for possible infections, drug interactions, and liver issues and initiated on lamotrigine for seizure prophylaxis. The clozapine dose was gradually reduced with regular monitoring of levels and side effects. She later developed stroke-like symptoms, with a normal CT scan. The clozapine dose was reduced to 100 mg/day as clozapine toxicity can mimic stroke/TIA. Repeat levels were 483 mcg/l. The patient's mental and physical health remained stable after this.
Results: Clozapine is an effective antipsychotic agent with a dose range of 200 mg/day to 450 mg/day, the maximum licensed dose up to 900 mg/day. In clinical practice, the dose of clozapine is usually adjusted to provide plasma concentrations of 350–600 mcg/L. Acute infection can increase clozapine levels by reduced expression of CYP1A2 due to increased inflammatory cytokines and increase in a-1 acid glycoprotein. Acute infection and illness can lead to significantly increased clozapine levels and presumed toxicity, but symptoms of toxicity may be minimal or absent as the concentration of unbound drug is not increased. Certain drugs such as antibiotics and enzyme inducers can also affect levels.
Conclusion: Drug monitoring of clozapine is not a routine practice; certain clinical situations warrant multiple comorbidities, increasing age, polypharmacy, infections (pneumonia), and recent surgery, if poor (reduced) clozapine metabolism is suspected. Monitoring can help minimise the risk of toxicity. Patients should be evaluated for dose-related side effects such as constipation, seizures, cardiac arrhythmias and seizure prophylaxis should be considered if very high clozapine plasma levels.