suicidal thoughts were a normal part of being human, delaying my pursuit of any mental health support. Conversely, after my suicide attempt, such language left me feeling isolated, triggering vivid flashbacks. My journey to recovery has frequently been overtaken by thoughts that my past mental health is what solely defines me as a person.

**Results:** This case study proposes that the increasing use of statements like 'I am going to kill myself' reflects a deeper societal need for connection to others, yet it also diminishes autonomy over when and how individuals process their own mental and spiritual experiences. Overcoming mental illness is a difficult battle, often shaking one's sense of purpose in life. Reflecting on these experiences is essential for growth, but our society must help create a mindful and respectful space for this to happen.

**Conclusion:** A single case study goes a long way in proving that at least one individual has been affected by the use of mental health phrases by others. Whether that is the case for every person who has been mentally unwell at some point in their life or not, it is important to raise awareness of the negative setbacks it can have for vulnerable individuals. Further research should aim to recruit more participants affected by mental illness, gathering more evidence to either support or challenge the findings of this case study.



## Zolpidem for Catatonia Refractory to Benzodiazepines in Resource-Limited Settings

Ms Holly Hodge[1], Mr Shaikh Ullahansari[1] and Dr Blake Berry[2]

[1]Texas A&M College of Medicine, Dallas, USA and [2]John Peter Smith Hospital, Fort Worth, USA

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**Aims:** Catatonia is a neuropsychiatric syndrome characterized by a paucity of movement and speech. Benzodiazepines are the mainstay of treatment for catatonia, but a subset of patients do not respond. While electroconvulsive therapy is another treatment option for catatonia, access can be limited. This case report discusses the use of zolpidem, a hypnotic non-benzodiazepine GABA-A receptor modulator, in a patient with benzodiazepine-resistant catatonia.

**Methods:** A 19-year-old male presented to a hospital in the United States from jail custody with altered mental status. His medical history was notable for psychosis with paranoid delusions and severe catatonia.

The patient reportedly had severely reduced oral intake for the past month, with almost no intake at all in the prior eight days. His presentation, which included psychomotor retardation, mutism, and posturing, raised a high clinical suspicion for catatonia.

Initial treatment with 1 mg of lorazepam every 6 hours was ineffective, and the patient developed tachycardia, raising concern for malignant catatonia. At this time, his differential diagnosis included schizophrenia. His treatment regimen was adjusted to include olanzapine for suspected schizophrenia, memantine for catatonia treatment augmentation, and metoprolol for tachycardia. Despite this regimen, along with escalating lorazepam doses up to 7 mg three times daily, the patient remained severely catatonic. A trial of clozapine also failed to yield significant improvement.

Given the patient's limited response to benzodiazepines, zolpidem was introduced. He showed rapid improvement in his catatonic symptoms, including markedly improved speech, oral intake, and overall participation. Zolpidem was dosed throughout the day to limit drowsiness. By day 30, the patient demonstrated substantial recovery, with minimal catatonic symptoms and improved engagement in daily activities. He was discharged home on a regimen of zolpidem, clozapine, and memantine.

**Results:** A subset of patients with catatonia fail to respond to benzodiazepines, necessitating alternative treatments. Prompt intervention is crucial due to the life-threatening nature of catatonia and its numerous complications. While electroconvulsive therapy is often effective, its availability can be limited. Zolpidem, acting through a distinct mechanism of GABA-A receptor subunit binding, may offer an effective alternative for benzodiazepine-resistant cases.

**Conclusion:** Further research into zolpidem and other alternative therapies for catatonia is warranted, especially in settings where electroconvulsive therapy is not accessible. Zolpidem's potential as a treatment for benzodiazepine-refractory catatonia deserves further investigation.



## Acute Outpatient ECT for Depression: Case Series of the First Clinical Pilot in Ireland

Dr Saba Inam, Dr Mirat Qari, Dr Henry Roberts, Dr Thomas McMonagle and Dr Martha Finnegan

Department of Psychiatry, Tallaght University Hospital, Dublin, Ireland

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**Aims:** ECT is a well-evidenced, cost-effective intervention for treatment-resistant depression. In Ireland acute (twice-weekly) outpatient ECT for depression has not been reported, though common elsewhere. Ireland has among the lowest number of inpatient psychiatry beds per person in Europe. We observed a clinical need for acute outpatient ECT for people who could not access elective inpatient care.

**Methods:** All cases provided written informed consent. A multidisciplinary (psychiatry, anaesthesiology, nursing) protocol for assessment and delivery of acute outpatient ECT was developed and implemented, cases described and feedback from stakeholders sought in an acceptability forum.

**Results:** Four medically stable patients (ASA Grades 2) completed acute outpatient ECT, receiving between n=6 and n=14 ECT treatments, attending from home. N=140 inpatient psychiatry bed days were saved, and n=45 community psychiatry reviews were required. No adverse events or medical interventions occurred. Three people had CGI outcome of "very much improved" and one person halted their treatment course when "minimally improved", citing lack of response. Stakeholder feedback in an acceptability forum highlighted the increased resource intensity of twice weekly community review for outpatient ECT, and the positive outcomes for treatment-resistant depression.

**Conclusion:** Acute outpatient ECT was safe and effective in this case series and resulted in n=140 psychiatry inpatient bed days being saved. There was an increased need for reviews from the community team during the treatment protocol. Medically stable patients with substantial social support were eligible for this pilot phase, thus a priority for future development must be equity of access to this effective intervention.