Methods. Two cohorts of psychiatry trainees in Tower Hamlet's East London Foundation Trust received four teaching sessions, each of one hour duration, on TFP theory and techniques. All the sessions were delivered online, using video teleconferencing software. 14 Trainees completed 2 questionnaires, pre- and post-teaching: the Attitude to Personality Disorder Questionnaire (APDQ) and the Clinical Confidence with Personality Disorder Questionnaire (CCPDQ). The APDQ asks the responder to score from 1–6 the frequency they experience certain feelings towards patients with PD. In the absence of a suitable instrument, we developed the CCPDQ consisting of a set of 13 questions rated on a 6-point Likert scale addressing key issues identified in TFP including establishing and maintaining the treatment frame and in implementing the 4 main techniques. We also conducted a 1-hour focus group post teaching which was videorecorded, transcribed, and analysed thematically.
Results. On quantitative analysis, the Wilcoxon signed-rank test indicated statistically significant improvements in the total APDQ score ($P = 0.003$, $r = 0.81$) and in the CCPDQ questionnaires ($P = 0.001$, $r = 0.88$).

The thematic analysis showed an overall positive effect of the TFP teaching on trainees' attitude and confidence: they felt it improved their understanding of the nature of personality disorder, their awareness and management of countertransference, awareness of object relations and relation dyads at play in the encounter.
Conclusion. Training junior doctors about TFP theory and techniques as applied to PD can significantly improve their attitude towards these patients and their technical confidence in the clinical encounter. Of note, our workshop is resource light and can easily be delivered by remote teaching. Based on these findings, teaching of TFP in the core psychiatric training curriculum should be considered.

Case Series Evaluating the Use of Combined Long Acting Injectable Antipsychotics in Three Patients Within Forensic Services

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doi: 10.1192/bjo.2022.98

Aims. Antipsychotic polypharmacy is a relatively common practice, despite a lack of robust evidence. In 2018, the National Clinical Audit of Psychosis evaluated the treatment of 8000 patients with a diagnosis of schizophrenia or schizoaffective disorder, and found 10% were receiving non-clozapine antipsychotic polypharmacy. This included 432 patients receiving one oral & one long acting injectable (LAI) antipsychotic and 2 patients receiving two LAI antipsychotics. An audit within our service, found that 24 of 88 (27%) inpatients were receiving non-clozapine antipsychotic polypharmacy. Of these, 3 were prescribed two LAI antipsychotics. A literature review found very limited evidence supporting the use of combined LAI antipsychotics, with publications relating to a total of 18 cases. Presented here is a case series, reviewing the use of LAI antipsychotic polypharmacy in three patients within Devon Partnership Trust.
Methods. The case series reports on three male inpatients, who are under the care of secure services within Devon Partnership Trust. All are currently prescribed two LAI antipsychotics. Two have a diagnosis of treatment resistant schizophrenia and one of schizoaffective disorder. All are complex, necessitating recurrent or lengthy admissions, and present with significant risk to others when unwell. In each case, there have been trials of multiple antipsychotics, but only one has had a previous trial of clozapine.
Results. Published case reports highlight the positive effects of LAI polypharmacy, noting an improvement in mental state and lack of adverse effects. The cases presented here show significant variability, with one patient improving significantly, the second to a lesser extent, and the third remaining under high level observations.

All cases are complex with decisions taken on a background of high risk, after multiple failed trials of medication.

Although no specific adverse effects were reported, none of the patients regained sufficient insight to engage in treatment decisions and physical health monitoring. It is therefore difficult to quantify the adverse effect burden and weigh this against perceived efficacy.
Conclusion. Combined LAI antipsychotic medication is a possible treatment option in complex individual cases. Prescribing decisions are based on perceived clinical benefit, and the evidence base remains limited, with little understanding of long-term effects or consequences.

Unlike high dose antipsychotics, there is no formalised guidance for prescribing combined LAI antipsychotics. Treatment targets and review processes were not always explicit. A more robust approach, would provide greater clarity around the practice and aid with future decision making.

Morning Pseudoneutropenia in a Patient With Borderline Personality Disorder Treated With Clozapine

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doi: 10.1192/bjo.2022.99

Aims. Neutropenia associated with clozapine affects up to 3% of patients. For the purpose of clozapine treatment, absolute neutrophil count (ANC) between 1.5–2.0 × 109/L is considered as amber result; requiring twice-weekly blood sampling until when it returns to normal. Interestingly, some patients on clozapine may develop transient neutropenia also known as Morning Pseudoneutropenia (MPN), or pseudoneutropenia. It is a phenomenon where normal diurnal variation of circulating white blood cells (WBC) and in particular ANC become more accentuated. In these patients, blood samples taken in the morning would tend to have amber results, while blood samples taken on the same day in the afternoon will have normal ANC. A case is reported where a patient with severe emotionally unstable personality disorder (EUPD) developed MPN 38 days after clozapine initiation.
Methods. AA is a 19-year-old white lady with a diagnosis of severe EUPD. Prior to starting clozapine, AA had tried several oral and depot antipsychotics, antidepressants and lithium without success. AA was started on clozapine. Her initial pre-clozapine blood count taken in the morning was WBC-5.8 x109/L and her ANC was 2.7 x109/L. AA improved quickly on clozapine. However, five weeks later, her first amber report was received. AA went on to have another six amber results before MPN was suspected. AA blood sampling was moved to the afternoon. There were no more amber results thereafter.
Results. To my knowledge, this is the first published case of a patient with EUPD treated with clozapine who went on to develop MPN. Recurrent amber results with samples taken before mid-day

should alert clinicians of this phenomenon. Of course, other causes of neutropenia need to be excluded.

It is noteworthy that most reported cases in literature though few, involves patients with treatment resistant schizophrenia. Being aware of this phenomenon may raise our suspicion index and hopefully reduce the need for frequent repeated blood tests and the need to stop clozapine given the risk of relapse and its implications.

Few cases have also been reported in patients with physical health problems such as Grave's disease, systemic lupus erythematosus, and lymphangioleiomyomatosis. Medications that have been implicated to potentiate ANC diurnal variation including clozapine, risperidone, prednisolone, methimazole, and sirolimus.
Conclusion. Morning pseudoneutropenia is an accentuated normal diurnal variation of WBC. Early detection by collecting samples in the afternoon when there are recurring amber results can reduce unnecessary repeated blood tests and can prevent premature discontinuation of clozapine.

A New Trainee-Run Insomnia Treatment Service for Patients Under Community Mental Health Teams

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doi: 10.1192/bjo.2022.100

Aims. Chronic insomnia is a common mental disorder that severely impacts the quality of life of those affected, increases the risk of comorbid mental disorder and physical illness, and makes treatment of other mental disorders less effective. It is particularly common in patients under secondary care mental health services. Once chronic, insomnia rarely resolves spontaneously. Cognitive behavioural therapy for insomnia (CBT-I) is a highly effective treatment that is recommended by the UK's National Institute of Health and Care Excellence as the first-line treatment. Despite this, CBT-I is not universally available or accessible throughout the UK. Therefore, LW obtrained training at a sleep clinic and then initiated, ran and evaluated a new CBT-I service for existing community patients within her NHS trust.
Methods. Patients received individual holistic assessments with a psychiatry trainee, a 5-session weekly virtual group intervention run by LW, and an individual 3-month follow-up. LW also trained other psychiatry trainees to run future groups, initially under supervision. Clinical rating scales were employed at initial assessment, following the final workshop and at follow-up.
Results. Seven patients completed all sessions, with five completing a 3-month follow-up review. All had suffered with chronic insomnia for over 5 years. All had moderate-to-severe insomnia on the Insomnia Severity Index (ISI) at assessment (mean 21.3), which had improved by the end of treatment (mean 14.3). All patients seen at follow-up either no longer had insomnia or had sub-threshold insomnia on the ISI (mean 7.2). From assessment to post-treatment to follow-up, mean scores on the Dysfunctional Beliefs and Attitudes About Sleep Scale reduced from 6.6 to 3.7 to 2.5, and mean scores on the Clinical Outcomes in Routine Evaluation–Outcome Measure reduced from 2.18 to 2.01 to 1.27. Mean scores on the Work and Social Adjustment Scale reduced from 23.6 (severe impairment) at assessment to 7.0 (low impairment) at follow-up. Two patients stopped taking sleeping tablets during the treatment, and remained off them at follow-up.
Conclusion. Group CBT-I can be a highly effective treatment for insomnia for patients under CMHT services. In this service run by a psychiatry trainee without formal sleep medicine or CBT qualifications, the efficacy of the intervention on insomnia symptoms, as well as on anxiety and depressive symptoms, was similar to the efficacies found in clinical trials and in specialist sleep clinics. CBT-I can be easily learnt by psychiatry trainees and likely other professionals with psychological expertise, which could increase the availability and accessibility of this effective treatment.

Patient and Staff Perspectives on a Non-Restrictive Leave Protocol at Springbank Ward, Specialist Personality Disorder Unit

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doi: 10.1192/bjo.2022.101

Aims. Springbank Ward is a specialist unit for patients with a diagnosis of emotionally unstable personality disorder (EUPD). Psychiatric wards often use restrictive practices to try and minimise suicide risk. Using risk assessment checklists to decide whether to grant leave is one example. Research shows that it is not possible to predict suicide at an individual level, regardless of the assessment method used, so we questioned the utility of such an approach. A previous evaluation of our leave protocol showed that patients and staff would favour a less restrictive and more personalised approach. We introduced a new protocol that eliminated use of checklists, replacing them with an optional 1:1 conversation with staff before leaving the ward. Our aim was to gauge patient and staff satisfaction with the new protocol and investigate their views on the change.
Methods. Data were obtained through structured interviews with staff who assessed risk (nurses and psychiatrists) and patients. 9 patients and 8 members of staff were interviewed between 9–19 March 2021. Interviewees were presented with diagrams of both the new protocol and old risk assessment checklist and asked a series of questions, including: rating their satisfaction; any potential improvements; and whether they would prefer the previous or current protocol. Thematic analysis of interview answers was used to explore patient and staff perspectives. Two authors independently analysed the interview transcripts, before discussing any discrepancies to reach a unified set of themes, subthemes and codes.
Results. Both patients and staff gave the new protocol an average satisfaction rating of 4.1/5. Thematic analysis generated five themes: "taking ownership", "autonomy Vs restriction", "staff-patient interaction", "staff expertise" and "protocol efficiency". Most interviewees agreed that the new protocol supported patients in taking responsibility for their safety, helping to prepare for life in the community. The protocol was considered minimally restrictive and more efficient than the previous system. The importance of communication and trust between patients and staff, as well as the use of staff intuition in holistically assessing risk, was emphasised. Potential disadvantages included the perceived riskiness of reducing restrictions and difficulty seeking support early in the admission.
Conclusion. In general, the new protocol is rated highly by patients and staff and is considered to be minimally restrictive