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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**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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**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