

**Methods.** The data were collected from core psychiatry trainees in West Midlands (CT1 – 3) through a Microsoft form sent via the Faculty support team and data are collected (June 2021) from CT's perspective. It involved demographics and questions evaluating quantitative and qualitative overview of educational supervision. We used HEE guidelines and RCPsych recommendations. Similarly, we used a modified questionnaire to anonymise educational supervisors' (ES) perspectives in the West Midlands School of psychiatry annual Education day conference (January 2022).

**Results.** Trainees Perspective: 40% out of 123 trainees responded, of which 35% were CT1, 40% were CT2, and 25% were CT3. 59% said that CT in psychiatry was their first training job in the UK. In the quantitative overview, 25% of the trainees responded their 1st contact with their ES was more than six weeks after beginning their 1st post, and 29% expressed their 1st meeting more than six weeks following the start of their 1st post in the academic year. 67% met adequate standards in the quantity of educational supervision in an academic year. In qualitative overview, 19% didn't understand the role of ES, and 54% didn't know how to raise concerns about ES. The thematic analysis of the feedback suggested points of improvement as supervisions not being 'tick-box' exercises and accessibility of ES.

The trainer's perspective: 60% of attendees responded, 71.4% were ES. All the responding ES answered that they would arrange their 1st meeting six weeks before the start of the academic year. Almost all suggested the most common difficulty in educational supervision as availability of time, considering clinical workload for both ES and CTs. All respondents knew that the number of meetings would be as many as trainees wanted in an ideal/needful situation. From the thematic analysis of free text, almost all responded lack of time was a barrier in providing the supervision reflecting on their ability to engage with the trainees.

**Conclusion.** Suggested recommendations were to raise awareness among the trainees through workshops at induction to explain the aim and objective of educational supervision and to have a guided list of suggested topics to discuss in supervision. For trainers, further training about HEE & RCPsych guidance about Educational supervision would be helpful. Educational leads need to engage in job planning. A comparison between Trainees and trainers feedback through the GMC survey may help to compare with the national picture.

### Is the Grass Greener on the Other Side? A Qualitative Comparison Study of Psychiatry Trainee Views in England Compared to New Zealand

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**Aims.** The Royal College of Psychiatrists census (2019) highlighted that 10% of all consultant psychiatrist roles remain unfilled. This pattern is replicated elsewhere in the UK with 7.8% in Northern Ireland, 9.6% in Scotland and 12.7% in Wales. This increase in consultant vacant posts is indicative of the recruitment challenges to psychiatry. On the other hand, the 2017 New Zealand Medical Workforce survey report showed recruitment to psychiatry was up by 8.2% in 2018 compared to 2017. I conducted a qualitative comparison study to look at psychiatry trainee views regarding their training in a UK and

New Zealand deanery at similar stages of their psychiatric training.

**Methods.** Questionnaires were distributed to current psychiatry trainees in the Capital and Coast District Health Board (CCDHB) based in Wellington, New Zealand and Birmingham and Solihull Mental Health Foundation Trust (BSMHFT), UK who were between years 1–3 of their psychiatry training. Qualitative information was collated from the questionnaires regarding various aspects of their training. Areas of focus were; pros and cons of psychiatry training, suggestions for improvements, supervision, access to annual leave and study leave, teaching, encouragement to attend courses and involvement in research.

**Results.** Of the 33 current trainees working in CCDHB, 48% were immigrants from the UK, previously having worked in the NHS.

17% of BSMHFT trainees felt valued in their organisation, compared to 64% in New Zealand.

27% in New Zealand considered switching to another training programme, whereas none considered switching in the UK. Burn out was quoted as a problem in both New Zealand and the UK. 100% were able to take annual leave with ease in New Zealand, compared to 0% in BSMHFT.

**Conclusion.** This small study gives a closer insight into the views of trainees in New Zealand, a place often thought as being more attractive for doctors to work in. What this study shows is 2 key factors; there are shocking differences in the quality of trainee experiences between New Zealand and the UK, however New Zealand is not free from issues around trainee retention, although the study does show overall trainee satisfaction being greater in New Zealand. Feeling valued, supported and leading a life with better work-life balance appear to be key driving factors for UK graduates leaving the UK and there is more that could be done to make trainees in the UK feel more valued and prevent burn out.

### Improving Education and Confidence for Junior Doctors Regarding Physical Health Matters on Psychiatry Wards: The Physical Health Huddle

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**Aims.** The COVID-19 pandemic highlighted a greater need for multidisciplinary input for psychiatric patients with complex physical comorbidities at Reaside Forensic Medium Secure clinic. It was also felt that junior doctors would benefit from support in managing complex physical health matters as well as issues arising whilst on-call in order to improve morale and support their educational needs. We aimed to add to existing services by offering junior doctors a regular discussion group (Physical Health Huddle) to support with complex cases, share different perspectives on patient treatment and open conversation regarding issues arising whilst on-call. We further hoped to improve communication, provide education for junior trainees with limited experience of forensic psychiatry and support their involvement in patient care and multi-disciplinary meetings.

**Methods.** Junior doctors were invited to a monthly informal Huddle (in person and online) and supported to propose patients

for discussion. A proforma was supplied to assist. The junior doctor presented the summary and following discussion we explored various ideas on how to manage the patient's physical health. Feedback was provided to the patient teams afterwards and short before and after questionnaires were used to monitor effectiveness and collect feedback.

**Results.** The result showed a significant increase in support felt and individual feedback highlighted the need to continue this effort. The Huddle therefore provided a safe reliable space to freely discuss concerns regarding the day-to-day management or escalation of complex physical health issues on psychiatric wards as well as on-call.

**Conclusion.** The Huddle successfully created a sustainable, effective and interactive short learning session which has shown to be effective in engaging trainees in this vital area and help us meet our aim. This format further has the potential to be refined and rolled out to a wider audience in the future to improve learning throughout the trust regarding physical health matters.

### Generating Recommendations for Medical Curricula to Reduce Stigma Towards Psychiatry From Medical Students

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**Aims.** In 2021, we completed a project entitled: 'Stigma Towards Psychiatry: Correlating Personal Experience with Existing Literature' – 'International Congress Award Winning'. We aim to use the themes generated from this to inform recommendations to medical educators to reduce stigma in their curricula towards psychiatry.

**Methods.** Using previously identified themes, we generated a set of recommendations aimed at the pre-admission, pre-clinical and clinical phases of learning. Pre-admission themes include: misconceptions of the role of the psychiatrist and disinterested medical applicants. Pre-clinical themes include: dissociation of psychiatry from medicine and clinical role modelling. Our final category, clinical, includes: cross-speciality support for psychiatry, pathophysiology in de-stigmatisation of psychiatric disease, discrimination of the aspiring psychiatrist, psychiatric exposure in training not seeing conversion of students to psychiatrists and the role of unofficial mentors in continuing enthusiasm for the speciality. Division in this way gave us multiple opportunities to look for areas of potential intervention in influencing medical student's views on psychiatry. Further influencing our recommendations was the feedback from a group of consultant psychiatrists this project was presented to.

**Results.** Addressing the themes driving stigma from the previous project saw us producing a list of recommendations targeted at each phase of medical school. (1) Pre-admission stage: selecting candidates who are more psychologically minded by recognition of A level psychology as a core subject; encouraging people with experience in mental health settings to apply for medical training (Srivastava et al, 2018); highlighting psychiatry as a medical career in the prospectus. (2) Pre-clinical stage: making students aware of their unconscious stigma towards psychiatry; clearer links made to psychiatry in early medical school to relevant biochemistry,

anatomy, physiology and pharmacology (Mahli et al, 2003); tutor / doctor led psychiatry based extracurricular groups; highlighting mental health aspects of functional neurological disorders and disorders within rheumatology such as fibromyalgia. (3) Clinical stage: making clinicians aware of their unconscious stigma towards psychiatry; encouraging cross-speciality support for psychiatry; improving contact with psychiatrists on mental health placements (Archdall et al, 2013).

**Conclusion.** Stigma towards psychiatry extends from medical school and into clinical practice. It feels important that medical school curricula should be altered in order to change students' experience of psychiatry within medical school. The recommendations target each stage the themes were identified within. Our local medical school has agreed to let us present this at their curriculum meeting which may pave the way for further refinement and implementation of our suggestions.

### Barriers to the Use of the Mental Health Treatment Requirement as Part of a Community-Based Criminal Sentence for Mentally Disordered Offenders

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**Aims.** Due to the high rates of mental disorder in prison there have been a number of initiatives to divert mentally disordered offenders out of custody. One of these is the Mental Health Treatment Requirement (MHTR): a criminal sentence available as part of a Community Order, offered as an alternative to short-term custodial sentences in an attempt to address recidivism and encourage concordance with community psychiatric treatment. In spite of the prevalence of mental disorder amongst offenders, MHTRs represent less than 1% of all community sentences. Here we aim to identify obstacles to the use of the MHTR at sentencing and to suggest ways of overcoming them.

**Methods.** A literature review and brief case series will be used to identify and illustrate what may be obstructing or limiting the use of the MHTR. The terms 'MHTR' and 'Mental Health Treatment Requirement' were searched on Google, Google Scholar, Athens, and PubMed, and results analysed for recurrent themes. The issues encountered clinically by one of the authors who referred three defendants for MHTRs in psychiatric sentencing reports in 2021 were reviewed with the same purpose.

**Results.** The main barriers to the use of the MHTR which were identified were issues related to a lack of clinician awareness and experience, homelessness and housing, and service structure and provision. There may be a reluctance for Community Mental Health Teams (CMHTs) to accept offenders onto their caseloads, and there are challenges in obtaining assessments and recommendations for MHTRs. There are difficulties in securing an MHTR for homeless defendants on remand for whom identifying housing prior to sentencing, and thus a CMHT to supervise the MHTR, can be challenging. The MHTR assessment and referral process is more lengthy and cumbersome than that for most other disposals, leaving the defendant awaiting sentencing (potentially in custody) while the referral is processed.

**Conclusion.** Suggested solutions to improve access to the MHTR include increasing clinician awareness and confidence by providing teaching and training, and multi-agency meetings to enhance communication and create an understanding amongst