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

Dr Jack Blake[1]* and Dr George El-Nimr[2,3,4]

[1]University Hospital Northwest Midlands, Stoke On Trent, United Kingdom; [2]North Staffordshire Combined Healthcare NHS Trust, Stoke On Trent, United Kingdom; [3]Royal College of Psychiatrists Faculty of Neuropsychiatry, London, United Kingdom and [4]Keele University Medical School, Stoke On Trent, United Kingdom
*Presenting author.

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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

Miss Fatima Saleem[1] and Dr Hector Blott[2]*

[1]St George's University, London, United Kingdom and [2]South West London and St George's Mental Health NHS Trust, London, United Kingdom
*Presenting author.

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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