trajectories; (2) parental empowerment and stress regulation act as key mediators of sustained engagement and parent–infant synchrony; and (3) feasibility and equity are determined by delivery model, workforce capacity, accessibility and adaptability (for example, hybrid or telehealth models).

Heterogeneity in terminology, study design, intervention duration, and outcome measures (including criteria used to define autism likelihood) was acknowledged as a limitation constraining synthesis across the studies in this review.

Despite these limitations, findings were integrated into a Developmental-Relational-Implementation model to support clinicians and commissioners in selecting, timing, and delivering Parental-Mediated Interventions that are feasible and adaptable within real-world health systems.

Conclusion: The Developmental-Relational-Implementation model offers a pragmatic framework for clinicians, commissioners, and policymakers to guide the delivery of Parental-Mediated Intervention in early autism care. This review positions Developmental-Relational-Implementation-informed approaches as family-centred, equitable, and scalable by capitalising on relational engagement, developmental neuroplasticity, and the practical realities of healthcare delivery. To support scalable and sustainable expansion, furtherresearch should incorporate mechanistic markers, qualitative assessments of parental outcomes, and health economic evaluation.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Examining Unmet Need for Adults Presenting Self-Harm and Suicidality in Jaywick

Dr Emma Kaminskiy

Anglia Ruskin University, Cambridge, United Kingdom

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Aims: Adults living in deprived coastal communities face disproportionately high rates of self-harm and suicide, yet little is known about the barriers they experience when attempting to access preventative and mental health support. This study explored how Jaywick residents navigate existing support pathways, identified key barriers and unmet needs associated with accessing services for self-harm and suicidality, and examined approaches that may strengthen engagement and early intervention within this coastal setting.

Methods: Two stakeholder workshops were conducted with 14 participants from statutory health providers and community and voluntary organisations operating in Jaywick. Workshops were audio-recorded, transcribed verbatim, and analysed using reflexive thematicanalysis. Discussions focused on experiences of service navigation, barriers to accessing care for self-harm and suicidality, and opportunities for system improvement.

Results: Three overarching themes were identified. First, access barriers: digital exclusion, low literacy, and poor signposting impeded residents' ability to access mental health support, leaving many dependent on others for referrals. Second, social and cultural dynamics: deep-rooted mistrust of statutory services, normalisation of symptoms, and strong community tribalism hindered help-seeking and engagement. Third, vulnerability and risk: entrenched cycles of poverty, addiction, trauma, and isolation were prevalent, with migrants and refugees experiencing added disadvantages. Fragmented service provision meant that those with co-occurring needs frequently fell between service thresholds and were often only supported at crisis point.

Conclusion: Barriers to accessing support for self-harm and suicidality in Jaywick are complex, intersecting, and reinforced by long-standing structural inequities. Enhancing trust, embedding services locally, and reducing digital exclusion are essential to improving early intervention and access. Co-produced, community-based models, including health navigation and outreach approaches, offer promising routes to addressing the significant unmet needs within this coastal community.

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Carriers of Care-Cultural Translation, Recognition, and Belonging Among International Medical Graduates in the NHS

Dr Anindya Kar

Cornwall Partnership NHS Foundation Trust, Bodmin, United Kingdom. Goldsmiths, University of London, London, United Kingdom

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Aims: International Medical Graduates (IMGs) are essential to the delivery of care in the UK National Health Service (NHS) but their work is often examined through workforce metrics rather than lived clinical practice. So far, this study presents one of the first in-depth UK-based ethnographic analyses of IMG doctors, examining how they negotiate professional belonging, authority, and recognition, and how cultural translation and plural clinical reasoning operate under conditions of rota pressure, visa constraint, and racialised evaluation.

Methods: An interpretative qualitative study was conducted using ethnographic methods. Data were generated through 13 life-history interviews with IMG doctors working across NHS hospital settings, supported by reflexive field diaries and digital ethnography within IMG professional WhatsApp groups. Participants represented a range of specialties, grades, contract types, and intersectional identities. Data were analysed thematically using concepts from medical anthropology and sociology, with attention to recognition, translation practices, and institutional governance. Ethical approval was obtained from the relevant institutionalethics committee, all participants provided informed consent, and data were anonymised in accordance with governance and data protection requirements.

Results: IMGs contributed more than clinical labour. Participants described sustained cultural translation work, rendering care credible across accents, professional rubrics, and patient moral worlds. Many enacted plural clinical rationalities, making small, evidence-tested adaptations to standard protocols that stabilised pressured services and supported patient trust. These practices were frequently unrecognised or misread as inefficiency. Professional recognition was unevenly distributed and patterned by race, accent, grade, and visa status, with service-heavy posts limiting access to protected training and clinical voice. Performance, strategic silence, and low-visibility resistance emerged as everyday tactics through which IMGs preserved dignity, mitigated risk, and advocated for patients.

Conclusion: The NHS already functions as a global medical system but its infrastructures of recognition remain misaligned with this reality. Recognising cultural translation as clinical work and embedding safe mechanisms to evaluate plural practices could improve equity, patient safety, and workforce retention. Practical implications include protecting training in service-heavy roles, decoupling communication assessment from accent policing,