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The simulated mental health review tribunal – a valuable training tool for senior house officers?

AIMS AND METHOD
Psychiatric senior house officers currently receive little formal training in how to give testimony at mental health review tribunals. The development of a simulated tribunal workshop for trainees, which is group-based, interactive and experiential in nature, with meaningful user and carer input is described.

RESULTS
We have incorporated simulated mental health review tribunal workshops into our academic programme and these have been successfully evaluated. Feedback has shown a marked increase in the confidence levels of trainees regarding tribunals.

CLINICAL IMPLICATIONS
The new Mental Health Act (England and Wales) is likely to place increasing demands on psychiatrists, in terms of giving testimony at mental health review tribunals. Simulated training for senior house officers, incorporating user and carer perspectives, can improve their skills and confidence in presenting at actual tribunals.

'What we have to learn to do, we learn by doing' (Aristotle)

Mental health review tribunals provide essential safeguards for those detained under the Mental Health Act 1983 in England and Wales. The past 20 years has seen an increase in the number of applications to such tribunals (Crossley, 2004). The decisions of the tribunals are influenced greatly by the recommendations of the responsible medical officer (RMO) or their representative (Shah & Oyebode, 1996). Since 2001, the burden of proof has also shifted from the patient to the responsible authority in tribunals (Lodge, 2005).

Psychiatric trainees currently receive little formal training in how to deal with the anxiety-provoking, 'quasi-court' tribunal process. The proposed changes to the Mental Health Act 1983 are likely to increase the workload for healthcare staff (Whyte & Meux, 2003; Sarkar & Adshead, 2005), increasing the likelihood of senior house officers (SHOs) having to give testimony at tribunal hearings.

We describe how we have organised regional 'simulated mental health review tribunal' workshops to equip our trainees with the skills they require to perform competently at tribunals.

Origins and aims

A regional survey of our 15 psychiatric SHOs (based at Tolworth, Queen Mary's and Barnes Hospitals) revealed that 7 have given testimony at a tribunal previously, but only a few felt comfortable with the experience. The current learning objectives for SHOs state that they should demonstrate knowledge of the procedures for mental health review tribunals and statutory managers hearings (Royal College of Psychiatrists, 2002).

We set up a focus group (including representatives from psychiatry, social services and user/carer organisations) to produce more detailed objectives.

These were modified, after feedback from our regional SHOs, resulting in a list of eight core skills in which SHOs should develop confidence:

- knowledge of the tribunal panel, its composition and purpose
- responding to questions from the panel's 'legal member'
- responding to questions from the panel's 'medical member'
- responding to questions from the panel's 'third member'
- responding to questions from the patient's solicitor
- presenting information with the patient present at a tribunal
- awareness of the patient's perspective at a tribunal
- awareness of the carer's perspective at a tribunal.

A training session was designed, based upon these objectives, using a modified version of Kaufman's 'seven principles to guide teaching practice' (Kaufman, 2003) (see Box 1).

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Recruitment of user and carer representatives

We decided not to recruit a currently detained service user or a current carer, as it can be difficult for them to express their feelings openly (Fadden *et al*, 2005). Instead, we advertised for a user volunteer via the regular newsletter of our local branch of Mind (National Association for Mental Health). A service user (A.G.) was recruited who had personal experience of the tribunal process and wished to improve the experiences of psychiatric in-patients. A regional mental health carers' worker (S.R.), with experience of a range of carer issues relating to detention and tribunals, was recruited as the carer's representative.

Planning

Two months before the session, our focus group met to finalise their roles (Table 1), select a topic area, and produce a simulated medical tribunal report and list of questions (see Appendix 1) that could be asked during the tribunal process. The sessions are incorporated into our regional academic programme for SHOs.

Structure of a session

A tribunal training session lasts 2.5–3 h and requires a room that can hold 20–25 people, including space to set up a mock tribunal.

Introduction and case presentation (40 min)

The lead facilitators give an outline of the session and the focus group SHO presents a simulated case history. A copy of the medical tribunal report is circulated, with time allowed for questions to clarify the case.

Small group discussions (50 min)

The SHOs are divided into four groups (A–D), spending 25 min discussing the likely questioning they may face from the panel's medical member (group A), lawyer (group B), third member (group C) and the patient's solicitor (group D). Each group spends the next 25 min discussing the therapeutic relationship with the patient before and after the tribunal and the associated effect on the carer.

The focus group members act as equal facilitators in these discussions, rotating around groups A–D. The SHOs are unaware of the actual tribunal questions. At the end, one SHO is randomly selected (using a series of marked cards) from each of the four groups.

Table 1. Roles of focus group members in a simulated mental health review tribunal training session

Focus group member (*n*)	Facilitative roles for the session
Consultant and specialist registrar (2)	Lead coordinators Role-play the patient's solicitor and tribunal's medical member
Specialist registrar (1)	Role-plays the tribunal's legal member
Social worker (1)	Role-plays the tribunal's third member
Senior house officer (1)	Presents the simulated case history Role-plays the patient
User and carer representative (2)	Facilitate the small group discussions and feedback

Box 1. Seven principles to guide teaching practice[1]

- Active learner participation by having an interactive session
- Session should reflect a real-life clinical scenario/situation (including some anxiety production)
- Take into account learners' current level of knowledge/experience and ability to handle the new training scenario
- Learners should be given the opportunity for self-directed learning via small group discussion
- Learners should be given constructive feedback from teachers/peers, and support for clinical practice
- Learners should be given an opportunity to assess their own and/or their peers' performance, and helped to develop new perspectives (including awareness of patient/carer issues)
- Detailed planning of the session, incorporating a range of enthusiastic teachers, can ensure that learners have good role models

1. Adapted from Kaufman (2003).

The simulated tribunal (45–50 min)

After an introduction by the panel's chair, the four selected SHOs come up in turn, and face 10–15 min of questioning from a panel member (this is videotaped). The SHO from group A faces questions from the panel's medical member, the SHO from group B faces questions from the panel's lawyer, and so on. They can bring with them a copy of the tribunal report and any accompanying notes.

The members of the tribunal use the earlier collated questions as a guide for their questioning, but have the flexibility to alter them depending on the SHOs' responses. The simulated patient occasionally interrupts the SHOs' testimony to potentially put them off.

Constructive feedback (30 min)

Feedback, highlighting areas done well and areas of difficulty, is given by all members of the tribunal and the user/carer representatives. Observations made by the SHOs who watched the proceedings can highlight general concerns. The lead facilitators can advise on how to handle difficult areas of questioning by incorporating snapshot role-plays.

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Evaluation method

Trainees complete an evaluation form at the beginning and end of the session, allowing them to indicate, via a series of 5-point Likert scales (ranging from 'strongly agree' to 'strongly disagree'):

- to what extent they 'feel confident' in each of the session's learning objectives
- the overall usefulness of the session.

Our evaluations have demonstrated that the mean number of objectives in which our trainees have felt 'confident' rises from 3 to 7 after attending the first session. All trainees (n=16) who attended our pilot session felt that 'it was a realistic snapshot of an actual tribunal and a useful way of improving their skills'. Although the majority (13, 81.3%) felt that 'user/carer involvement was helpful', one trainee strongly disagreed with this and two were neutral. In the free-text feedback, some trainees commented that 'it was strange getting used to the user/carer input'.

Strengths and weaknesses

The clinical simulation parallels published examples in other branches of medicine (Ker *et al*, 2005), and ensuring trainees are unaware of the tribunal members' questions mimics the real-life situation. Randomly selecting SHOs after the small group discussions ensures that they all participate fully in the discussion groups. The user/carer representatives facilitate trainees' awareness of user/carer issues, which fulfils a mandatory College requirement (Fadden *et al*, 2005).

The ultimate success of these sessions is dependent on the abilities and experience of the facilitators, particularly in ensuring that the tribunal questioning runs smoothly. Although the SHOs have no prior knowledge of the case, the salient points are reinforced via the case presentation and group discussions.

Reflections of a service user (A.G.)

My inclusion in the focus group ensured that user perspectives were considered from the outset (e.g. by incorporating proactive user feedback throughout). The mock tribunal highlighted how addressing patients respectfully and minimising medical jargon can significantly improve communication. Presenting medical information sensitively is of paramount importance in retaining good doctor–patient relationships and the session illustrated that labelling a patient's perception of their situation 'paranoid' or 'delusional' was unhelpful; a fair hearing demands that the patient's view be genuinely encouraged and considered. People generally value being spoken to openly and honestly, and trainees concluded that time spent with patients (outlining the report) before the tribunal may prove beneficial. The experiential learning was enhanced by placing SHOs in the 'hot-seat' during the mock tribunal, giving a small 'live-taste' of the doctor–patient power imbalance inherent in a tribunal setting.

Reflections of a carer's representative (S.R.)

I felt accepted as a facilitator by guiding the SHOs on the carer's perspective. Although I had to prompt some groups on the issues to consider (e.g. confidentiality, carer burden), this was welcomed by the trainees. Ensuring that the carer has been involved in the team's care plan can improve the SHOs' testimony, as the carer has a unique longitudinal view of the ups and downs of the patient's illness. Senior house officers can also learn how to sensitively discuss carer's concerns in a tribunal setting.

Meaning and implications

Simulation-based clinical training allows practise of skills in a realistic, but safe environment (Moorthy *et al*, 2005). Although simulation is being used to help trainees prepare for the MRCPsych examination (Naeem *et al*, 2004; Pryde *et al*, 2005), there are few published examples of simulation-based clinical training in psychiatry. Our sessions have allowed trainees to identify ways of improving their technique and coping better with the tribunal process, including:

- prior to the tribunal, having contact with the carer and discussing the medical report with the patient
- structuring the report with clear subheadings (underlining the key points)
- directing answers to the solicitor's questions to the panel members, using eye contact
- verbally acknowledging that the patient may disagree when giving information
- after the tribunal, arranging a debriefing with the patient.

It is important to clarify the reasons for including user/carer representatives at the beginning of each session, particularly for doctors used to medical model training formats. Further work is needed to see if the positive effects of our sessions can be maintained in actual tribunal settings. A College training video for SHOs on mental health review tribunals could also help.

Our sessions provide an adaptable method for preparing SHOs for giving testimony at mental health review tribunals. Should we take a contemporary view of Aristotle's comments, by adding 'in a simulated environment' to his original statement? We think so, but do you agree? If so, welcome to the world of simulation-based psychiatry.

Declaration of interest

A.G. is a service user currently researching individuals' experiences of mental healthcare.

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Appendix 1

Questions used in a simulated mental health review tribunal training session involving a patient with schizophrenia (Mr S.) appealing against detention under section 3 of the Mental Health Act 1983 (England and Wales).

Tribunal's 'medical member'

- Which category of mental disorder does Mr S. have?
- What is the diagnosis? Provide evidence to support this
- What is the nature of his illness (including the chronicity, previous response to treatment and prognosis)?
- What is the degree (i.e. current manifestations) of his illness?
- Why should Mr S. still be liable to detention?
- Is detention necessary for the health and/or safety of Mr S., or the protection of others?
- What is his insight?

Tribunal's 'legal member'

- Are you representing the detaining authority?
- Is there a reasonable alternative to detention? Why not?
- What is your care plan?
- If you were presented with this patient today, would you section him? Why?

Tribunal's 'third member' (with experience of social services)

- If Mr S.'s illness is manageable with medication, could he live in the community with a robust package of care?
- How many of his presenting problems are drug-related and how is this being addressed?
- How will you ensure that the suggested planned admission to rehabilitation has a good outcome, given that he has limited insight?
- Have you considered section 25 after-care arrangements?

Patient's solicitor

- Has your consultant reviewed your report? When did he last see Mr S.? When did you last review my client?
- Is my client making any attempt to harm himself now?
- What evidence have you got of self-neglect?
- With significant support, why could he not cope in the community?
- Could the home treatment team not be involved?
- Have you involved my client's family in your suggested care plan?

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