

SHORT REPORTS ON SIMULATION INNOVATIONS
SUPPLEMENT (SRSIS)

Our journey to developing simulated patients for a psychiatric setting

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Introduction

Our project began with anecdotal and focus group feedback that junior doctors felt under-prepared for starting posts in psychiatry. We chose a simulation-based education (SBE) approach to address this issue because the areas identified were the decision-making and interpersonal aspects of assessments of patients who are mentally unwell. We designed a scenario involving a depressed patient which covered the areas of risk assessment and the mental health act. The second scenario was of a patient with a drug-induced psychosis which addressed the use of verbal de-escalation techniques and rapid tranquilization protocols.

We were aware that psychiatry as a specialty has been slow to adopt SBE and that this is partly due to challenges around authentically portraying patients with mental illness [1]. Our programme required complexity which would reflect real practice. We had access to the Simulated Patient Programme from the local medical school. Simulated patients (SPs) are trained in medical student scenarios both in physical health and communication skills. We subsequently learnt a lot about what is required to produce an authentic portrayal of a psychiatric patient in SBE.

Innovation

We created actor briefs which included background information about each character's diagnosis and symptoms and how they may present in response to these symptoms. There were suggestions of verbal and non-verbal responses to participant cues. These briefs were provided in advance to the SP so they could prepare. We met with SPs prior to the session and talked through the characters, intended learning outcomes and transition points.

Unfortunately, this preparation did not prove sufficient. In the depression scenario the SP agreed to stay in hospital voluntarily despite this derailing a key learning objective about use of the mental health act. When debriefing the SP after the scenario, they commented that the doctor 'had been so nice' that they wanted to stay in hospital. More problematic was the portrayal of psychosis; this was inconsistent and failed to demonstrate the distress or acute disturbance needed to drive the scenario towards the learning objectives. Additionally, we were left with feelings of disquiet about how inauthentic the portrayals of the patients felt and worries as to whether we were inadvertently replicating stereotypes.

For the next iteration of the teaching, we changed our approach. As a group of psychiatry trainees we felt able to use our experience to improve the portrayal

Table 1: Selection of participant written feedback taken from sessions after SP development

'Actors very useful'
'Good acting – challenging'
'Engaging and realistic scenarios'
'Realistic scenarios, applicable material'
'Great to show working scenarios with simulated patients for new starts'
'Realistic simulation allows practice of language/comm skills and “real-world” problem-solving'

of the patients in the scenarios. We decided to take on the role of the patient experiencing psychosis ourselves. An advantage of using faculty for this was that we were able to develop the character iteratively, by reflecting together and giving feedback on each portrayal. The result was a considerably more nuanced representation.

Additionally we recruited a non-clinical member of the psychiatry faculty to act as the depressed patient. We held a workshop session with her and the rest of the team, and worked to develop a more fully formed character. She was encouraged to think about how she may act if she was feeling low in mood, considering elements such as tone of voice, body posture and potential impact on self-care. A portrayal emerged which was sympathetic and realistic.

Evaluation

The session consists of two scenarios and debriefs lasting 2 hours. To date it has been delivered as part of eight psychiatry induction programmes. Group numbers varied between 4 and 10 participants; training has been delivered to 138 junior doctors commencing their first post in psychiatry. We have evaluated this programme more broadly looking at the impact on participants' self-efficacy in a number of areas relevant to the teaching, immediately after the session and again at 3 months. These data show an increase in self-efficacy and qualitative data evidenced use of learning in practice.

When participants were asked what they found useful about the session many commented on the acting or realistic nature of the scenarios as positives, as illustrated in Table 1.

What's next?

We are proud of the programme and want to ensure its longevity. One challenge has been the dependence on psychiatry trainees in order to keep it running. As previous education fellows we have excellent links with the local simulation manager. This has allowed us to start training Simulation Technicians to take over the SP role. These technicians have a wide range of experience and through a preparatory workshop were able to incorporate previous observation of the sessions into developing their own portrayal of the characters.

Involvement of people with lived experience of mental illness is missing from this project. We know this could add

huge value and allow us to develop the characters further and improve authenticity [2]. We are in discussion with the 'Edinburgh Patient Partnership Supporting Assessment and Teaching' with a view to working in collaboration with people with lived experience of mental illness in the near future.

Declarations

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Authors' contributions

All the authors were directly involved in the project and contributed to the writing and editing of the paper.

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Competing interests

None declared.

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