

## CLINICAL SKILLS: SUICIDE AND SELF-HARM HISTORY

*Suicide and self-harm histories are very common stations during Psychiatry OSCEs, as they gauge a student's ability to assess a patient's risk profile. You can be quite focussed in your approach during these stations, as you are not necessarily expected to get a 'diagnosis,' but rather comment on the risk of the patient. This is also a situation that you will encounter multiple times as a junior doctor, particularly on an A+E rotation. A structured approach is important with patients who may not want to engage, and a "before, during, after" approach can give you a good idea of what a patient's short and long-term stressors are, allowing you to judge the severity of their condition. An examiner will expect you formulate a plan for the patient, most importantly the decision of whether to send a patient home or not. The best students will have a good idea of which psychiatric services are available, and be able to discuss an option or two besides admission, even if this is the best option.*

**Sample vignette:** You are an FY2 in Liaison Psychiatry services. Mr Smith is a 47 year old gentleman who has taken an overdose of paracetamol. He has been medically cleared by the A+E team. Please take a history from him and discuss a plan with the examiner."

**Introduction**

- "Hello, my name is X, I'm one of the doctors with the psychiatry team."
- Start with a broad open question, but one that puts the patient at their ease: "I understand you've been through a tough time recently. What happened to bring you here?"
- Reflect the patient's concerns back to them: "It sounds like things have come to a head – is that why you decided to take the paracetamol?"
- If it feels comfortable, you can ask intention directly here: "did you take the tablets with the intent of ending your life?" This will frame the rest of the conversation usefully. If you feel you need a little more time for this, wait until you ask about the attempt explicitly when explore the "during" section.

**OSCE-Aid Tips**

Don't be afraid to address the overdose directly: "is that when you decided to take the paracetamol?" will get you close to finding a short-term trigger. "What did you hope to happen? Did you mean to take your own life?" is a really important question in gauging the severity of risk.

**Before**

- What has been happening recently to make you feel this way? How long has all this been going on? (*Onset of symptoms*)
- Determine long and medium-term stressors such as:
  - Recent death of a partner/family member
  - Marriage breakdown
  - Loss of a job/pressure at work
  - Co-existing mental or physical health problems
  - Financial trouble
- Remember a host of other psychiatric conditions other than depression present with suicide, such as mania, schizophrenia, personality disorders and PTSD. "Have you had any contact with mental health services before?"
- Screen for mood/affective symptoms: "How has your mood been (scale of 1-10)? How's your sleep, appetite, energy levels? Have you been able to enjoy anything recently? (*Affective disorders*)"

- Screen for psychotic symptoms, if appropriate: “Do you ever feel as though someone is interfering with your thoughts?” “Did anyone tell you to do this?” (*Schizophrenia/mania*)
- Screen for alcohol/drug use: “How much do you drink on a daily basis/do you take any recreational drugs? Has this been a problem in your life prior to today?” (*Drugs/alcohol as precipitating factor*)
- Have you ever tried to do anything like this before? Have you ever cut yourself, or tried to harm yourself in any other way? (*Increased risk from past history*)

### During

- Screen for signs that this was a serious attempt with a high risk of completion. Someone who has taken steps not to be found, alongside acts of finality generally present a higher risk than someone who takes an overdose as a spur of the moment act and then calls an ambulance.
  - How long have you been preparing to do this? (*Look for long-term specific plans*)
  - What research did you do on how much to take/what to do? (*Ask about internet sites/research, and whether they know lethal doses etc.*)
  - Did you take steps not to be found? *I.e. locking doors, making attempt when and where others were not around.*
  - Did you take steps like closing your bank accounts, or leaving money to loved ones?
  - Did you leave a note, or tell anyone about it? *Was this to be found at a time after the completed act?*
  - Did you drink any alcohol, or take any other drugs at the same time? (*Use of alcohol increases risk of completed suicide*)

### OSCE-Aid Tips

Use silence as a tool in a psychiatric history. A patient who feels that you are talking too much may not feel comfortable enough to share key information with you. It can feel nerve-wracking to keep quiet in a time-limited OSCE station, but don't jump in with another question if a patient doesn't answer immediately. If you're getting nowhere, address the patient head on: “it seems as if you're finding it difficult to talk to me; is there anything I can do to make you more comfortable?” It is unlikely that a patient will completely shut down on you in an OSCE after this.

### After

- “How were you found? How did you get to hospital?” *An accidental discovery implies a higher risk than someone who locked themselves behind closed doors.*
- “How do you feel about having taken the overdose now?” *Testing insight*
- “What does the future look like to you at the moment?” *Protective factor: resilience and positive outlook*
- “We've explored some of the stresses in your life over the past few months/years. Do they seem any more surmountable to you now?” *Protective factor: problem solving*
- “Who is at home with you? Will they look out for you? Would I be able to speak with them about how you're doing?” *Protective factor: family/friends*
- “Do you currently see anyone from mental health services? Would I be able to speak with them?” *Protective factor: access to mental health services*
- If you were to go home now, do you think you would try to kill yourself, or harm yourself again? *Don't be afraid to ask this directly!*
- What would you like to happen now? *Ask this one directly too – patients saying they want to go home without acknowledging what they have done may be more risky, whereas a patient that is at high risk who “wants more help” could be amenable to an informal admission.*

Risk factors for completed suicide	Protective factors for completed suicide
<p>Previous suicide attempt</p> <p>Family history of suicide</p> <p>Co-existing mental illness, including:</p> <p>Affective disorders (most common)</p> <p>Schizophrenia</p> <p>Personality disorder (particularly borderline)</p> <p>Alcohol/substance mis-use</p> <p>Disabling, or painful physical illness</p> <p>Male gender</p> <p>Significant life events (e.g. loss of loved one)</p>	<p>Involvement of family and other support mechanisms</p> <p>Good contact with mental or physical health services that offer hope of improvement/resolution of condition</p> <p>Access to substance mis-use support services</p> <p>Cultural or religious beliefs that go against suicide</p> <p>Personality-based factors; i.e. “resilience,” conflict resolution skills or non-inflammatory ways of managing disputes</p>

### Risk assessment/Plan

- There are two ways to do this well – either stop, thank the patient and summarise to the examiner as you would in other stations, or you can frame your summary and plan as a discussion with the patient, hence involving them in the decision-making: i.e. “you’ve told me x,y and z which make me think that sending you home would be a bad idea; what do you think?”
- An examiner will want you to highlight the salient points from the person’s risk profile and then answer the question “is this patient safe enough to go home?” – in fact, people are almost never sent straight home from A+E with no further contact from mental health services, hence the best students will be able to answer this question in terms of the follow up patients might benefit from, or whether an admission might be of benefit.
- *Example summary: “Mr Smith is a 47 year old gentleman with a previous history of depression and suicide attempts who has presented after taking 24 paracetamol tablets and a bottle of whisky with the intent of ending his life. He took decisive actions not to be found such as locking his door, and closed down his bank accounts before taking the overdose. He was only accidentally found by his daughter, who stopped by. His long-term stressors have been his separation from his wife 6 months ago, the loss of his job and subsequent financial difficulties he finds himself in. His mood has been low, sleep poor and appetite reduced. He does not state any psychotic symptoms. He highlights his relationship with his daughter as a protective factor, but also states that he still feels hopeless and that he wishes that his attempt had been successful – he intends to carry out another attempt if he is discharged. I feel that in light of his high risk profile, Mr Smith may benefit from an informal admission to hospital, to which he is agreeing. I would like to discuss this with the senior on call, and bed manager at the local inpatient unit.”*
- In reality, many people end up being sent home from A+E with follow up from the Home Treatment, or Crisis Resolution Team – this may be an alternative to offer to your examiner in place of admission if the patient appears less risky.

## Options for discharge from A+E

- *GP follow up*: for very low risk patients. This would rarely be appropriate unless a patient had this as part of their specific care plan.
- *Discharge to community mental health team*: if a patient is known to a community team (such as a community support and recovery team/CSRT, or otherwise) and/or has a care coordinator, it may be appropriate to explore an urgent follow up with this team. Again, this is an option for low-risk patients, who have a good relationship with their community teams already.
- *Crisis or Home Treatment Team*: these are community teams who deal with high risk patients who can be safely managed at home and can (and often are the only way to) liaise with inpatient units for admission if the situation deteriorates. They may also be useful if you wish to check for medication compliance. They can visit up to two, or sometimes even three times a day.
- *Informal admission to hospital*: if you feel the patient is not safe enough to go home then the only option is to admit. The best way to facilitate this is to ask them to come into hospital voluntarily. This will require good negotiating skills, that you would not normally be required to demonstrate in an OSCE, but the best students will demonstrate an aptitude for this throughout their history-taking.
- *Admission to hospital under section*: If you feel your patient is not safe enough to go home, and is refusing admission, you may want to recommend that they are assessed under the Mental Health Act for an admission under section 2 (assessment/treatment). If they are refusing to stay in hospital, you may wish to consider detaining under a section 5(2) until the MHA assessment takes place, though if the patient is in A+E this does not apply (it is not an "inpatient" unit), so the patient will need to be assessed to see if they can be held under the Mental Capacity Act instead.

### OSCE-Aid Tips

A good student will be able to show an examiner that they know how on-the-ground services are delivered. Asking someone who is known to a community team things like "do you have a care coordinator?" demonstrates that you have actually spent your clinical attachments finding out how services actually work. Similarly, being able to show that you know how secondary services knit together demonstrates that you have not just learned from a textbook, but have useful, practical experience in psychiatry.