

Station Number

AFFIX CANDIDATE
LABEL HERE

CANDIDATE No:.....

Instructions for Candidates

Scenario

You have been asked to assess Susan Ross, a 25-year-old woman who has recently taken an overdose of their antidepressant medication. She is currently in the 'Short Stay Ward' at the Accident and Emergency Department.

You have been asked by the medical team whether she can be allowed to go home. There are no outstanding blood results.

Instructions

Take a history in order to assess her risk of further self-harm, and to consider the need for admission to hospital.

**PLEASE REMEMBER TO HAND YOUR IDENTITY LABEL TO THE
EXAMINER**

Station Number

AFFIX CANDIDATE
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History Taking: Suicidality

CANDIDATE No:.....

Instructions for Patients

Answer questions based on the following scenario.

Do not volunteer information unless asked.

This station tests the candidate's ability to take a history from a patient, and make a risk assessment after an overdose.

You are Susan Ross, a 25-year-old woman.

Key Attributes

You are obviously depressed, and upset about being in hospital. You appear a little embarrassed and withdrawn.

History of Overdose

- You have been thinking about suicide on and off for the last couple of weeks, and you decided to take an overdose two days previously
- You did some research on the Internet to find the lethal dose of Imipramine
- You renewed your prescription a week early so that you would have enough.
- Before taking the overdose, you took all the tablets from the blister pack. You wrote a note to your mother and your boyfriend. You told your boyfriend that you were going to visit your mother, and vice versa.
- You wrote out a quick will. You had thought that the tablets you took would stop your heart. This was your intention when you took the tablets.
- You were found by your boyfriend when he came back unexpectedly to get his bank card. You regret being found and wish that you had succeeded.

Recent depressive symptoms

- Your mood has been low for months. You are tearful and irritable.
- Your sleep is poor and you have lost weight
- Your concentration is poor
- You have no energy or motivation. You cannot get any pleasure from friends or family.
- Your self-esteem is rock-bottom, and you feel worthless and negative.

Past psychiatric history

- You have been seeing a psychiatrist for the last eight months because of depression. Your antidepressant was changed to Imipramine from Sertraline about a month ago, but since the Sertraline was stopped you have been feeling increasingly low,

anxious, and 'agitated'.

- You have not taken an overdose before, but you had thought about it in the weeks before you first saw a psychiatrist
- This is your first episode of depression. You are currently prescribed Imipramine 125mg twice a day. You have no more tablets at home.

Mental State

- You still have some thoughts about killing yourself, but since you ended up in hospital and everyone is rallying around, you have some ambivalence about whether you would do it again.
- You have no active intention, but couldn't say that you would never do it again

Personal history

- You live with your boyfriend who is supportive
- You have worked in a clothing store since you left school, and are now assistant manager. You have been off work for the last two weeks.
- You have been drinking a little more recently but you don't drink in the mornings; you don't have any cravings for alcohol; and it doesn't dominate your life, or interfere with your life.
- There is no history of illicit drug misuse. You smoke 10-15 cigarettes a day.

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History Taking: Suicidality

CANDIDATE No:.....

Instructions for Examiners

***REMEMBER TO ASK THE STUDENT FOR THEIR IDENTITY LABEL AND
AFFIX IT TO THE TOP OF THE MARK SHEET.***

This OSCE station tests the candidate's ability to quickly assess important risk factors in a patient following an overdose. Essential skills to be tested include:

1. Ability to establish rapport with a distressed patient
2. Sensitivity when asking about details of the suicidal behaviour
3. Knowledge of predictors of risk following an overdose
4. Ability to ask important questions relating to further risk

At the next station, the candidate will be asked to present their history to the 'on-call' consultant over the telephone.

Station Number

Examiner's Name:

AFFIX CANDIDATE LABEL HERE

History Taking: Suicidality

CANDIDATE No:.....

Marking Sheet

Please circle the appropriate mark for each criterion. The standard expected is that of a psychiatric Senior House Officer.

Criterion	Performed competently	Performed, but not fully competent	Not performed		
Approach to the patient – Rapport, empathy, and style	2	1	0		
Degree of preparation (one point for each, up to a maximum of 3):					
• Planning	1	½	0		
• Suicide note	1	½	0		
• Last acts	1	½	0		
Circumstances of overdose (one point for each, up to a maximum of 2):					
• Alone	1	½	0		
• Intervention unlikely	1	½	0		
• Precautions against discovery	1	½	0		
After the act (one point for each, up to a maximum of 4):					
• Didn't seek help	1	½	0		
• Stated wish to die	1	½	0		
• Believed the act would result in death	1	½	0		
• Regrets its failure	1	½	0		
Recent history of depressive symptoms	1	1	0		
Current mental state	1	1	0		
Relevant past psychiatric history (one point for each, up to a maximum of 3):					
• Past history of self-harm	1	½	0		
• Past Psychiatric history	1	½	0		
• Current medication	1	½	0		
• Social history (particular attention to risk factors such as drug/ alcohol misuse)	1	½	0		
Overall Approach to Task	4	3	2	1	0

Score (Max 20)

Overall Grading of station

Clear Pass

Borderline

Clear Fail

Trickcyclists' Tip Sheet

This is one OSCE that is probably considered so important that if you fail it, you are likely to fail the whole exam. Regardless of your views on the ability of psychiatrists to 'prevent' suicide, the people who set the exam will expect you to be able to assess risk post-overdose/ self-harm competently.

Even though you will have done this hundreds of times before, people often end up asking irrelevant questions – remember that you only have 7 minutes: you don't need to know where they went to school. Stick to a plan and use some form of structure to your questioning – the Beck Suicidal Intent Scale (SIS) or the Pierce Suicide Intent Scale are both useful, and is given below. They should not replace good clinical assessment and judgement, however.

Don't forget that you may be asked to present the history over the telephone to the 'duty consultant'. You might find it helpful to scribble some basic notes so that you don't forget everything. If you present the history in a structured way, you will appear much more competent than if you follow a circuitous route. Remember that the consultant may be woken up at 3 a.m., and won't want to know all the names of the patient's 12 brothers and sisters.

The Beck Suicidal Intent scale (Beck & Steer, 1989)

Score out of 10. A score of ≥ 5 is considered significant risk.

1. *Preparation*
 - a. planning in advance
 - b. suicide note
 - c. final acts
2. *Circumstances*
 - a. alone
 - b. intervention unlikely
 - c. precautions against discovery
3. *After the act*
 - a. didn't seek help
 - b. stated wish to die
 - c. believed the act would result in death
 - d. regrets its failure

Pierce Suicide Intent Scale (Pierce, 1977)

Circumstances

1	Isolation	0	Someone present
		1	Someone nearby or on telephone
		2	No-one nearby
2	Timing	0	Timed so intervention probable
		1	Intervention unlikely
		2	Intervention highly unlikely
3	Precautions against rescue	0	None
		1	Passive (e.g. alone in room, door unlocked)
		2	Active precautions
4	Acting to gain help	0	Notifies helper of attempt
		1	Contacts helper, doesn't tell
		2	No contact with helper
5	Final acts in anticipation	0	None
		1	Partial preparation
		2	Definite plans (e.g. will, insurance, gifts)
6	Suicide note	0	None
		1	Note torn up
		2	Presence of note

Self-report

7	Lethality	0	Thought would not kill
		1	Unsure if lethal action
		2	Believed would kill
8	Stated intent	0	Did not want to die
		1	Unsure
		2	Wanted to die
9	Premeditation	0	Impulsive
		1	Considered less than 1 hour
		2	Considered less than 1 day
		3	Considered more than 1 day
10	Reaction to act	0	Glad recovered
		1	Uncertain
		2	Sorry he/she failed

Risk

11	Predictable outcome	0	Survival certain
		1	Death unlikely
		2	Death likely or certain
12	Death without medical treatment	0	No
		1	Uncertain
		2	Yes

To score, sum the scores under each of the three categories (circumstances, self-report, and medical risk). The significance of the score is as follows:

0-3: low intent

4-10: medium intent

>10: high intent

References

- Beck, A. T. & Steer, R. A. (1989)** Clinical predictors of eventual suicide: a 5- to 10-year prospective study of suicide attempters. *Journal of Affective Disorders*, **17**, 203-209.
- Pierce, D. W. (1977)** Suicidal intent in self-injury. *British Journal of Psychiatry*, **130**, 377-385.