

Objective Structured Clinical Examination  
**Mock Exam Auckland April 2005 - Station Bye for 1**

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**This is a reading “bye” station**

**Instructions to Candidate:**

**You have 17 (seventeen) minutes to complete this station.**

**You are a psychiatry consultation-liaison registrar, in a general hospital. You are about to respond to a referral written by a medical ward houseofficer regarding a patient, Alice. Before you visit the ward, you locate Alice’s past Consultation-Liaison (C-L) department records, to obtain some background information. Her main mental health records are currently unavailable but there is some information in the C-L notes. She is supposed to be having follow-up from the local CMHC as far as you can tell. You were not able to talk to a staff member at the CMHC who knew Alice, as the receptionist said that her usual doctor had left the CMHC and that her therapist had been away on leave for 4 weeks. The receptionist was unclear what cover arrangements had been made for Alice during her therapist’s absence, and has said she will try to locate the relevant staff member and have them call you back later.**

**Your tasks are to:**

- 1. Read the information provided from her C-L notes**
- 2. Read the referral letter regarding Alice, also provided**

Please do not make marks or notes on the records and letter provided.  
These items of information will be available again to you in station 2.

You can make your own notes on the scrap paper provided, and can take that with you into station 2, where you will continue with this scenario.

## **History about Alice from the C-L records**

Alice Smith is a 27 year old European woman. She lives alone in a rented flat. She is estranged from her family, being an only child whose father died of cancer when she was 6 years old, and who has a very difficult relationship with her mother. Alice has a history of sexual abuse in childhood. The perpetrator was her stepfather when she was aged 8-10. She tried to tell her mother but her mother apparently accused her of lying and did not listen. The marriage to this man however broke up a few months later so the abuse ceased. She had no counselling in her youth for this, but has had intermittent psychotherapy from 3 therapists at various centres, since age 22.

Alice has no formal psychiatric history before age 22, but when aged 9 she had a period of bedwetting which resolved after several months. She has later told assessing staff that she was depressed "since I was 6." At age 22 she failed a nursing training course and took an overdose of codeine, leading to her first C-L contact. She had at that point had chronically low mood and poor self-esteem and had a few old lacerations to her arms. There had been no actual suicide attempts prior to that, but she described feeling chronically suicidal and having frequent thoughts of ending her life, mostly with no clear plans however. She has taken a further 5 overdoses requiring admission subsequently – more recently these have been of paracetamol. On 2 occasions she required IV N-acetylcysteine treatment for these.

Alice has tried psychodynamically orientated therapy and CBT across the years, and is currently working with a therapist at the local CMHC who uses a combined psychodynamic/DBT approach. It is noted in the file after a prior discussion with her therapist that Alice tends to idealise her lost father, and that she has a lot of anger towards her mother.

After failing nursing training, Alice had a number of relatively short-lived jobs as an aide caring for the elderly in rest homes. She resigned from her last job after an argument with the manager and has been unemployed for 2 months. She has had periods of social welfare benefits either sickness benefit or unemployment benefit, in the past.

Alice has no current close relationship. She has a history of brief unstable relationships, at times with men who were physically abusive. She has not been in a close relationship for several months. She has a small number of close female friends, but says that people often let her down so she does not have a wide social network. She sometimes goes to a local craft group as she likes to do patchwork and make stuffed animals.

Alice does not drink alcohol, smoke cigarettes or use illicit drugs. She is not on any psychotropic medications currently. In the past she used to abuse zopiclone but was weaned off this 2 years ago. She is well apart from the lacerations, with no significant medical history. She has scars on her arms from past superficial lacerations. She does not have a GP but uses emergency private A&E services at times.

Alice was last admitted medically to the same ward as currently, a month ago. At that time she had again taken a paracetamol overdose. Prior to that her overdoses had in general been about a year apart but not occurring at any specific time of the year. She was assessed by the C-L service. The stressors at that time were recorded as her psychiatrist having left the CMHC to return to the UK, the pending leave by her therapist, plus pressure on Alice from her mother who wanted Alice to move in with her and share accommodation so as to save rent. The doctor from the C-L team who assessed Alice a month ago (not yourself) noted in the file that contact with the CMHC was needed to see what additional supports could be put in place across this stressful time for her. However, she was then admitted acutely to the psychiatric ward and no further notes have been made. There is no discharge summary from the psychiatric ward in the C-L file. You have tried to call the ward to get a summary, but her notes were in transit to medical records and were not available. The ward receptionist looked up the electronic record system and said she was discharged home as an informal patient after 3 days on the ward.

You note that there is a Crisis Management Plan in the C-L file, dated a year ago.

**Crisis Management Plan for Alice Smith      Date: 10/4/04**

**Introduction**

Alice has a diagnosis of Borderline Personality Disorder. She experiences frequent suicidality, especially at times of increased stress and difficult life events. This plan is designed to assist Alice to manage painful and difficult feelings using coping techniques which she has learned. Alice has developed considerable resources and is ultimately responsible for her own safety. This plan is aimed to support her in gradually developing healthier and less harmful ways of coping.

**Aims of Plan:**

To provide appropriate and useful crisis support so as to assist Alice

**Duration of Plan:**

The plan will be reviewed after 6 months.

**Regular Support and Crisis Services Available**

- 1) Weekly therapy from Claire Mallone (CMHC therapist)
- 2) Monthly follow-up from Dr Rob Taylor (CMHC psychiatrist)
- 3) Our Crisis Services will provide:
  - (a) Telephone and face to face supportive contact (see format over)
  - (b) Elective respite within a budget (see format below)
  - (c) Assessments of safety (see over).
  - (d) Hospitalisation (if requested or not) when there is considered to be an imminent risk of loss of life
  - (e) If Alice has already self harmed we will ensure she seeks medical care (arranging this if needed) and any psychiatric contact will be deferred until her medical state has stabilised
- 4) Crisis Services will not provide the following:
  - a) Respite or Bureau Nurses beyond the elective budget
  - b) Staff will not act to prevent minor self-harm other than by providing support to help deal with feelings and the situation
  - c) Crisis staff will not adjust or dispense additional medication
  - d) Changes or revisions to the Crisis Plan as such, except at proper review times

**Elective Respite**

1. Alice can phone and request a bureau nurse in her home up to a maximum of 12 days per three-month period
2. Such requests must be made by Alice (not others) between 9am and 8pm.
3. Staff will not make respite support conditional on risk, safety or anything else. It is Alice's responsibility to use the respite budget wisely

4. When requested, staff will check the budget record sheet (in the crisis management plan folder) and if within budget proceed to arrange respite
5. Staff will record the usage on the respite record sheet in the folder
6. If Alice has exceeded the budget no respite will be offered though other services will continue to be provided (e.g. phone support safety assessment, hospitalisation)
7. Alice will allow Crisis team staff to remove any stockpiled medications before the Bureau Nurse arrives

### **Supportive contact:**

The premise of phone support is that self harm/suicidality is a solution to the problem of how Alice feels. The goal is to find other solutions to cope with the feelings.

1. Phone calls are usually about 15 minutes. You may need to negotiate to call back if the team is extremely busy.
2. Listen supportively. Don't judge.
3. Try to focus on feelings rather than the content or the suicidal thinking. Remember that the distress Alice feels is real.
4. Discuss feelings in context of a chain of precipitating events. Formulate and summarise, but stay in the present, don't discuss past abuse or traumas
5. Review how she has already tried to cope with the feelings – e.g. go over the coping skills below and ask her to suggest what she could do to cope with how she is feeling.

### **Coping Skills**

Coping skills which sometimes help Alice to bear distress include:

1. Playing the relaxation tape
2. Listening to music
3. Calling Peggy or Amanda (friends)
4. Making a cup of peppermint tea
5. Sewing and doing craftwork

### **Safety Assessment**

Clients with borderline personality disorder often experience chronic suicidality. Normal principles of risk assessment apply but note:


1. Don't probe too much about safety.
2. Don't ask Alice to guarantee her safety - this is not a sensible proposition for her.
3. Remember that living with some risk is a difficult and everyday part of Alice's life - and is thus also a part of ours.

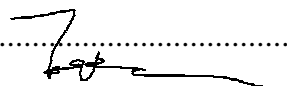
**Hospitalisation**

- a) Hospitalisation is only to prevent life threatening self harm
- b) Ensure a clear written plan is provided regarding the aims and length of the admission
- c) Hospitalisations must be short – not more than 3 days
- d) Admissions should ideally be elective. Only as a last resort should the Mental Health Act be used, and then only for 3 days as above.
- e) The focus of care must be to ensure safety and allow a brief period for Alice to regroup and regain more control of feelings
- f) Discussions with Alice during admission must only be about the feelings and events leading up to the lack of safety. Staff should not get drawn into past traumas or other issues
- g) Inpatient staff should not review or adjust plan or medications without consultation with relevant community staff
- h) It is likely that Alice will still be experiencing a level of risk to safety upon discharge, as this is a long-term issue for her.

**Agreement**

Signed:  Client ..... Date 12/4/04

.....  ..... Therapist ..... Date 12/4/04

.....  ..... Doctor ..... Date 12/4/04

**For consistency of responses across caregivers and services, copies of this plan are to go to:**

Alice, her friend Peggy, Claire Mallone her therapist (CMHC), Rob Taylor her psychiatrist (CMHC), C-L team

Referral Letter Regarding Alice

REFERRAL

DATE 20/4/05  
TO Psych Liaison team  
FROM Ward 10  
URGENCY: **URGENT**

ALICE SMITH	Team: BUTLER
BG2385	
DOB 5/9/77	AGE 27

*Thank you for seeing Alice. Prof Butler has asked that I refer her for a psychiatric assessment. She was admitted on 1/3/05 after an overdose of 50 paracetamol tablets and required N-acetylcysteine therapy initially. She has also lacerated her wrists and although there is no nerve or tendon damage these have not set well and are being dressed regularly.*

*Prof Butler is concerned that Alice was last admitted under similar circumstances only 1 month ago and he has requested that this time her suicidality is addressed and resolved. He is reluctant to discharge her while she is still suicidal and feels that transfer to the psychiatric unit on last admission was not helpful.*

*Earlier today she attempted to hang herself from a shower rail and she now has a nurse in charge. Please see her urgently.*

*Many thanks  
Gavin Perkins based here*