Workshop Case Scenario 1

Steve is a 35 year old male. He presents to A&E having taken a mixed overdose of his prescribed Fluoxetine mixed with 48 Paracetamol and a bottle of Vodka. When assessed by psych liaison, he disclosed that his relationship is falling apart and that he is considering leaving his partner of 5 years, with whom he has 2 twin boys aged 2.

He used to be a special forces marine with the army, and served in Pakistan but was dismissed from service due to PTSD, which he still struggles with. Additionally he has a background history of chronic back pain due to multiple spinal injuries sustained in the army, as a result of which, he can no longer work. He smokes Cannabis to manage his pain.

The overdose was precipitated after an argument with his partner in which she asked him to leave the property and threatened him that he would never see his children again. His children are the main focus of his life - his partner works whilst he is their full-time carer. Staff in hospital have observed that he brightened up when his children visited. His partner has visited, and whilst they have spoken, there seems to be ongoing tension.

He is happy to have his medications reviewed, and would be willing to consider therapy. However, he has declined the offer of an informal admission, on the basis that he is worried that if he were to leave his house, then his partner would never allow him back and he would lose access to his children.

With regards to the overdose, he minimises this, stating that he got fed up and acted impulsively, but that he was ambivalent about his intent. He stated that given his marine background, he has had special training in killing people effectively, and if he wanted to end his life, he could do this anywhere and anytime.

Additionally, he states that the family has no other support network around, and he is not sure who would look after his children while his wife is at work. He admits to ongoing suicidal ideation in the context of his current situation, but claims that he won't repeat his actions, and will be seeking the advice of a solicitor to progress to a divorce. He would also like further information around housing options given that he cannot work.

Mental state examination reveals marked features of depression, with low self-esteem, guilt, ideas of worthlessness and mild hopelessness. PTSD symptoms are still present, and these interfere with his sleep. No psychotic features present.

He has been prescribed Fluoxetine 40mgs, but no other treatments offered. He has been on this regime for the past 4 years, and has been compliant.

You are the on-call SpR / SHO, and psych liaison have rung you to discuss a risk assessment and a careplan.

Case Scenario 2

Lorna is a 47 year old lady, who is married, and lives with her husband of 20 years in a rural farmhouse. She has 3 children, all of which are adults, and the youngest has recently moved out to University. Her other 2 children live around 2hrs drive away, although they visit about twice a month with their 5 grandchildren in total.

She is very well known to services, and has been having multiple repeat presentations as well as admissions totalling 12 admissions over the past 3-4 years. Her diagnosis is unclear - she presents currently with features consistent with emotionally unstable personality disorder (borderline subtype). However, she also gives a clear longitudinal history of what appear to be brief hypomanic episodes during which she has impulsively purchased a brand new car, booked a trip to Australia, as well as had a pony delivered to their back garden.

Lorna presents roughly every 4-6 weeks to emergency services, often after having taken small overdoses and having rung the ambulance herself. Over the years, she claims to have taken in excess of 20 overdoses, normally of 10-15 paracetamol tablets, although she has only required NAC treatment on 2 occasions in 4 years.

Today, she presents to your outpatient clinic stating that she has been feeling depressed for the past few days. She states that her youngest daughter had been staying over with them for the summer holidays, but has just gone back to university. Her husband is very busy at work, and is having to work long days and weekends too, and she finds herself lonely at home, which is when she ruminates about committing suicide.

She also claims that her mood appears to coincide with her menstruation, stating that she can recall her difficulties starting in her teenage years when she hit puberty.

She has a background history of having been a police officer for a number of years, and had reportedly had a successful career. Her husband runs a construction business, and around 7 years ago, she had resigned from the police force to work from home managing her husband's business and accounts. Over the past 2 years, she has not been able to maintain this due to her mental health. They are however well-off financially.

The inpatient team have documented that there is no clear benefit to inpatient admissions - she does not engage with the therapeutic programme on the ward, is repeatedly asking for her medications to be changed at every ward round, and often ends up self-discharging out of frustration when her demands are not met.

Today, she is demanding to be admitted to an inpatient unit, as she states that her husband is away for the coming 4 days, and that she can't possibly be at home on her own. When you try to explore additional support in the community, she states that she has plans to take an overdose, or to 'kill myself' if she isn't admitted. Asked to elaborate, she states that she will find a way, and becomes histrionic and hyperventilates.

Document a risk assessment / formulation, as well as a careplan for managing her presentation today.

Case Scenario 3

Luke is a 20 year old male, who has a history of contact with mental health services dating back to age 16. He has a dual diagnosis of polysubstance misuse as well as emotionally unstable personality disorder.

Up until 2 years ago, he had his own accommodation, and was also managing to hold down a job. Unfortunately, as his income increased, so did his cocaine and stimulant use, resulting in him being evicted from his property and made street homeless. He also accumulated significant drug-related debts.

Over the past 18 months, he has had 26 inpatient admissions, 11 episodes with CRHT, 4 admissions to a local crisis house in the community. He has been offered a key worker, but has not engaged. He has been offered psychological therapy, but has dismissed this. He shows no interest in quitting his substance misuse.

You are now the inpatient consultant. The nursing team would like you to review Luke because over the past 24 hours, he has smuggled cocaine and ecstacy onto the ward, and shared this with another 4 patients, one of which has learning disability and a heart condition. Additionally, he has been heard boasting with patients about how he can run rings around staff, and how he has planned a further drugs delivery to the ward. He has been on the ward for 5 days, having been admitted after going to the train tracks following an argument with his mother.

When seen in ward round, he states that he has no intention of quitting drug-use. He does not see any problems with his lifestyle, but he would like the mental health service to provide him with accommodation, or if not, he will end up killing himself and it will be the fault of the consultant.

There is a complex family background - he had a difficult relationship with his dad who was always critical of him being gay. Additionally, his sibling who was 2 years younger committed suicide 6 months ago after Luke had spoken to him about jumping off a cliff - his family blame Luke for his sibling's death, and for a few months had stopped all contact. Luke also claims that he had been raped in the past, and experiences flashbacks, although has always consistently engaged in any further exploration or support around the above.

Objectively, despite the multiple admissions and offers of support over the past 2 years, the drug use has clearly gotten significantly worse, and is felt to be the main driving factor underlying the risk. There are concerns that he may well end up accidentally killing himself, and multiple admissions have been following overdoses, going on train tracks or jumping in front of traffic, normally in a setting of his demands not being immediately met (i.e. manipulative context).

When asked what outcome he would like, he becomes passive aggressive and states 'you're the expert - you haven't provided me with accommodation, so if you discharge me, I will go straight to a cliff and jump off and it will be on your conscience'. The staff however do not feel there is additional benefit to ongoing admission, and are concerned about the vulnerabilty of other patients on the ward.

Document a risk formulation, and a management careplan.

Case Scenario 4

Dave is a 37 year old male, who moved to your catchment about 12 months ago, after being placed there by social services. He has physical health disabilities - he is markedly obese, has shortening of his right upper limb due to congenital malformation, as a result of which he has sustained significant bullying over the years.

Additionally, there is a forensic background history of assaults - he has been convicted of ABH on 3 occasions, as well as charged with but not convicted of GBH. Around 10 years ago, he was also convicted of indecent exposure to a minor. Over the past 8 years, there has not been any major offending history, other than a 2 year period under probation for stalking an ex-girlfriend. His forensic risk profile is a barrier to supported accommodation services.

He is on benefits, smokes 30-40 cigarettes per day, as well as regularly uses Cannabis and Cocaine. He is in rent arrears, has significant debts, and has faced eviction 3 times already for not paying his rent and for neglecting and damaging his property. He is deemed to have done this with capacity, and not as a result of mental illness. He is currently being evicted again.

He had a physical healthcare support package in the community to support him with his physical health needs- twice daily visits + once weekly support for shopping.

Historically, he lived in supported accommodation in his teenage years, and appeared to have been stable, and even managed to attend college and hold a job for a brief period of time. This came to an end when he started using drugs and offending.

The SHO in A&E has assessed him and asked you to see him as the SHO feels that he needs to be detained in hospital. Dave had self-presented to A&E stating that he intended to take all his prescribed medications as he was fed up of waiting for social services to allocate him a bigger house. Additionally, he had used up all his money on drugs the previous weekend, and now did not have any money left for food. He also disclosed that he is being chased by drug dealers for money which he owes them, and he was now ‘fed up of life’.

When you assess him, he claims to be depressed, claims to be hearing voices and seeing things. His history is overall inconsistent, and A&E staff reported that he had been chatting away and smiling with a few other patients earlier on. Additionally, they have not observed him to be responding to unseen stimuli. Nursing staff feel that he is being manipulative to gain an inpatient admission to escape his debtors and due to not having any money left.

His last 3 previous admissions had all been under similar circumstances - i.e. presenting threatening harm to self in order to gain admission. On 2 of these occasions, he had been admitted, only to discharge himself 2 days later against medical advice as he had received some money and wanted to go and buy drugs. On the remaining occasion, he had been discharged home with food vouchers and a plan in place for brief CRHT support.

He has a dual diagnosis of Mental & Behavioural Disorders secondary to harmful polysubstance use, with co-morbid mixed personality disorder (antisocial and borderline traits).

Document a risk assessment and outline a careplan for his ongoing care.

CARE PLAN TEMPLATE

- Summary of Reasons for my admission:

- Factors contributing to my admission:

- The team are regularly assessing my risk, and are particularly concerned about:

- The team will help me with the following areas that I am currently struggling with:

- The team have identified that I need support in these other areas, but they are unable to directly help with this. However, they will still support me by:

- The team are concerned about these factors, although they acknowledge the limited potential for change in the short-term (eg. during an admission or acute crisis period):

- CRHT may consider me for supported discharge following admission, with ongoing support at home. For this to be able to happen, the following areas need to be addressed:

5P APPROACH TO HISTORY & RISK…

- Predisposing Factors
- Precipitating Factors
- Presenting Factors
- Perpetuating Factors
- Protective Factors
- …… and a 6th ‘P’ ……. Pharmacology