ABC of mental health
Mental health assessment

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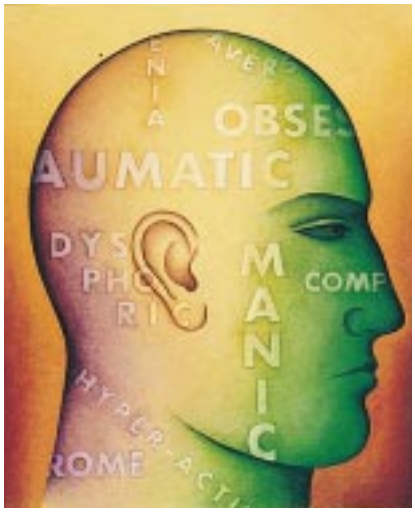
Psychiatry in health care

Psychiatry is a branch of medicine: it deals with those disorders in which mental (emotional or cognitive) or behavioural features are most prominent. The cause, presentation, and course of such disorders are influenced by diverse factors; their symptoms can be bewildering to patients and their relatives; and their management may require social and psychological as well as medical interventions. It is not surprising that this complex situation can lead to misunderstandings of the role of psychiatrists (who are neither social workers nor jailers) and myths about the practice of psychiatry.

The bulk of mild mental disorder has always been managed by family doctors. However, patients referred to psychiatrists are increasingly likely to be managed at home by community mental health services or, if admitted to an acute psychiatric ward, to be discharged after a short stay. Many former long stay patients have been discharged to the community with varying degrees of support and supervision. This series of articles will deal with the principles and practice of managing mental health problems.



Prevalence of psychiatric morbidity

All mental disorders—>20% of adults at any time suffer mental health problems; 40% of general practice consultations involve mental health problems

Depression (including mixed anxiety and depression)—10% of adults depressed in a week; 55% depressed at some time

Anxiety disorders—3-6% of adults have clinically important symptoms (about 1% each for phobias, obsessive-compulsive disorder, and panic disorder)

Suicide—5000 deaths and more than 100 000 attempts annually; 5% of all years of life lost in people aged under 75 years

Self harm—1 in 600 people harm themselves sufficiently to require hospital admission; 1% of these go on to kill themselves

Schizophrenia (and other functional psychoses)—0.4% of people living at home; 1% lifetime risk; 10 patients on a typical general practice list, but 10 000 not registered with a general practitioner

Bipolar affective disorder—0.5-1% of adults

Personality disorder—5-10% of young adults

Alcohol related disorder—4.7% of adults show alcohol dependence

Drug dependence—2.2% of adults living at home

Anorexia nervosa—1% of adolescent girls

Psychiatric assessment

There is a myth that psychiatric management cannot proceed without obtaining an extensive history that delves into all aspects of a patient's life. Diagnosis can take only a few minutes, but time must be spent fleshing out the initial impressions, assessing immediate risks, and collecting information about personal and social circumstances that modify symptoms or affect management and long term prognosis.

Accuracy is achieved by close attention to the pattern of evolution of presenting symptoms and examination of a patient's mental state, supplemented by a small number of specific questions. A complete psychiatric assessment requires a detailed personal history, which, if the doctor is not familiar with the patient, may be built up over a series of interviews. The important point is that such detail comes into play only once the basic problem has been clearly ascertained.

Good interview technique

Interview technique is important in all branches of medicine. A good psychiatric interview comprises a series of "nested" processes of gathering information in which gathering of general information is followed by specific questions to clarify ambiguities and confirm or refute initial impressions.

Open questions—The interview begins with open questions concerning the nature of the present problem, followed by more focused questions to clarify chronological sequences and the evolution of key symptoms. Open questions encourage patients to talk and to concentrate on the present situation and help to establish a rapport.

Closed questions—Specific closed questions (equivalent to the systematic inquiry of general medicine) should follow only once a clear outline of the underlying disorder has emerged. These questions form a checklist of symptoms often found in variants of the likely disorder but not mentioned spontaneously by the patient (such as diurnal variation of mood in severe depression).

Examples of open and closed questions

Open questions

What are the problems that brought you to see me (to hospital)?
Could you say a little more about them?
And...?
Is there anything else you want to mention (worrying you)?
Tell me about your daily routine (your family, your upbringing).
Are there any questions you want to ask me?

Closed questions

When did these problems (thoughts, feelings) begin?
How do they affect you (your life, your family, your job)?
Have you experienced anything like this in the past?
What do you think caused these problems?
What exactly do you mean when you say you feel depressed (paranoid, you can't cope)?
At times like these, do you think of killing yourself?
Do you hear voices (or see images) when nobody seems to be there?

Choice questions

Do you feel like..., or like..., or like something else?

Choice questions—Sometimes patients are not accustomed to answering open questions. This is often so with adolescents and children, who are more used to being told how they feel by adults. In this case a choice question may be more useful. This suggests a range of possible answers to the patient but always allows for replies outside the suggested range: "Do you feel..., or..., or something else?"

Initial assessment

The first and most important stage entails getting a clear account of current problems, including social circumstances and an estimate of concurrent physical illness (including substance misuse) that might influence the presentation.

Once the current situation is clear and rapport has been established, closed questions should be used to elicit specific items of history. Topics covered at this stage include patients' prior psychiatric and medical problems (and their treatment), use of alcohol and prescribed and illicit drugs, and level of functioning at home and at work. Initial suspicions of risk to the patient or others should be clarified gently but thoroughly.

On each topic the interview should move smoothly from open questions to more closed, focused questions

Risk assessment—It is a myth that asking about suicidal ideas may lead patients to consider suicide for the first time. Fleeting thoughts of suicide are common in people with mental health problems. Importantly, intensely suicidal thoughts can be frightening, and sufferers are often relieved to find someone to whom they can be revealed. Persecutory beliefs, especially those focusing on specific people, should be elicited clearly since they are associated with dangerousness. Patients who ask for total confidentiality—"Promise you won't tell anyone"—should be reassured sympathetically but firmly that the duty to respect their confidence can be overridden only by the duty to protect their own or others' safety.

Mental state examination

This bears direct analogy with the physical examination and is an attempt to elicit in an objective way the signs of mental disorder. The emphasis is now on the form as well as the content of the responses to well defined questions covering a range of mental phenomena. For example, the form of a patient's thought may be delusional, and the content of the delusions may concern beliefs about family or neighbours.

Physical examination

Relevant physical examination is an important part of the assessment and should follow as soon as is practicable. Usually, this will require only simple cardiovascular (pulse, blood pressure) and neurological (muscle tone and reflexes, cranial nerves) examination. Similarly, laboratory investigations should be performed as indicated, considering a patient's past health and intended treatment. The choice may be influenced by

- Patient's age
- Known or suspected concurrent physical disease
- Alcohol or substance misuse
- Intended drug treatment (especially antidepressants or antipsychotics)
- Concurrent medication (several drugs potentiate the cardiac effects of antidepressants and antipsychotics).

An electrocardiogram is now mandatory before starting certain antipsychotic drugs.

Dos and don'ts in the psychiatric interview

Do

Do let the patient tell his or her story
Do take the patient seriously
Do allow time for emotions to calm
Do inquire about thoughts of suicide or violence
Do offer reassurance where possible
Do start to forge a trusting relationship
Do remember that listening is doing something

Don't

Don't use closed questions too soon
Don't pay more attention to the case notes than to the patient
Don't be too rigid or disorganised: exert flexible control
Don't avoid sensitive topics (such as ideas of harm to self or others) or embarrassing ones (such as sexual history)
Don't take at face value technical words the patient might use (such as depressed, paranoid)

Remember

Put your patient at ease—it is an interview not an interrogation
Be neutral—avoid pressure to "take sides" or to collude with or against the patient

Important items of mental state examination

Appearance—Attire, cleanliness; posture and gait
Behaviour—Facial expression; cooperation or aggression; activity, agitation, level of arousal (including physiological signs)
Speech—Form and pattern; volume and rate; is it coherent, logical, and congruent with questioning?
Mood—Apathetic, irritable, labile; optimistic or pessimistic; thoughts of suicide; do reported experience and observable mood agree?
Thought—Particular preoccupations; ideas and beliefs; are they rational, fixed, or delusional? Do they concern the safety of the patient or other people?
Perception—Abnormalities including hallucinations occurring in any modality (auditory, visual, smell, taste, touch)
Intellect—Brief note of cognitive and intellectual function; is the patient orientated in time, place, and person? Is the patient able to function intellectually at level expected from his or her history?
Insight—How does the patient explain or attribute his or her symptoms?

The full mental state examination may be built up over several interviews by elaboration of these topics using increasingly direct, closed questioning.

Tests and investigations

Routine	
Full blood count (including red cell morphology)	These tests should be considered in all patients, but especially in view of:
Electrolytes	Age
Liver function tests	Medical history
Electrocardiogram	Future drug treatment
Urine drug screen	
Supplementary	
Chest *x* ray	As indicated by presentation or by findings on physical examination. They may be needed to confirm or refine the diagnosis, to exclude or define physical comorbidity, to monitor drug treatment
Skull *x* ray	
Breath alcohol	
Renal function	
Blood chemistry (eg glucose, thyroid function, drug levels, B_{12}, iron)	
Serology (eg syphilis, hepatitis, HIV infection)	
Special	
Electroencephalogram	These tests should be requested only after seeking specialist advice
Sleep electroencephalogram	
Computed tomography	
Magnetic resonance imaging	
Electromyogram	

Further inquiry

The second broad phase of assessment involves gathering information to place the present complaint in the context of a patient's psychosocial development, premorbid personality, and current circumstances. This phase also follows the scheme of open and then closed questioning, but, because of the breadth of the issues to be covered, it is often the longest component of a psychiatric assessment.

Much of this information may not be available initially, or may take too long to collect in a busy surgery or accident and emergency department. There is no reason to delay urgent management while this information is sought. Similarly, sensitive issues such as a patient's psychosexual history should not be avoided but can be elicited more easily when the patient's trust has been gained.

Making sense of psychiatric symptoms

Although psychiatric symptoms can be clearly bizarre, many are recognisable as part of normal experience. The situation is identical to the assessment of pain: a doctor cannot experience a patient's pain or measure it objectively but is still able to assess its importance. A pattern can be built up by comparing the patient's reported pain—its intensity, quality, and localisation—with observation of the patient's behaviour and any disability associated with it. Similarly, patients' complaints of "feeling depressed" may be linked to specific events in their life, to a pervasive sense of low self esteem, or to somatic features such as disturbed sleep and diurnal variation in mood.

Another myth is that the vagueness of psychiatric features makes diagnosis impossible. In fact, psychiatric diagnoses based on current classification systems are highly reliable. It is true that there are no pathognomonic signs in psychiatry—that is, most psychiatric signs in isolation have low predictive validity, since similar features may occur in several different disorders. It is the pattern of symptoms and signs that is paramount.

In practice, sense may be made of the relation between features and disorders by envisaging a hierarchy in which the organic disorders are at the top, the psychoses and neuroses in the middle, and personality traits at the bottom. A disorder is likely to show the features of any of those below it in the hierarchy at some time during its course but is unlikely to show features of a disorder above it. Thus, a diagnosis of schizophrenia depends on the presence of specific delusions and hallucinations and will often include symptoms of anxiety, depressed mood, or obsessional ideas; it is much less likely if consciousness is impaired (characteristic of delirium, which is higher in the hierarchy). Conversely, personality factors will influence the presentation of all mental (and physical) disorders since they are at the foot of the hierarchy.

Value of the psychiatric interview

The interview is more than an information gathering process: it is the first stage of active management. This may be the first opportunity for a patient to tell his or her full story or to be taken seriously, and the experience should be beneficial in itself. The length of the interview should allow time for intense emotions to calm and for the first steps to be taken towards a trusting therapeutic relationship. The balance between information gathering and therapeutic aspects of the interview is easily lost if, say, a doctor works relentlessly through a pre-set questionnaire.

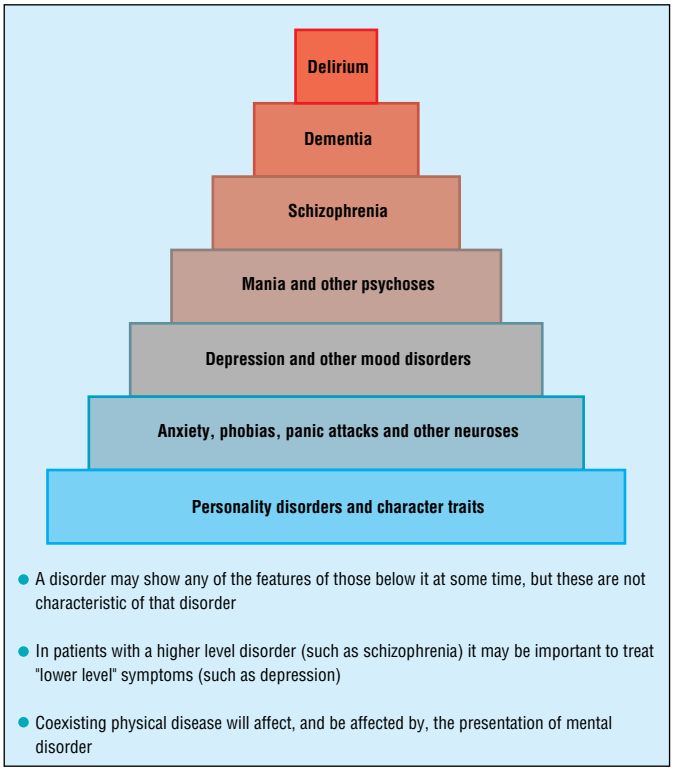
Some troublesome terms used in psychiatry

Psychosis is best viewed as a process in which the patient's experience and reasoning do not reflect reality. Psychotic symptoms (hallucinations and delusions) may occur transiently in several physical and mental disorders and are not pathognomonic of any disorder. Psychotic disorders are ones that are characterised by psychotic symptoms

Neurosis is a portmanteau term for disorders in which anxiety or emotional symptoms are prominent. It is falling from use since it is difficult to define, has been applied too broadly, and gives no guide to aetiology, intensity, or course

Delusion is a false belief held with absolute conviction and not amenable to argument (incorrigible) or to explanation in terms of the patient's culture. It may be bizarre, but this is not necessarily so

Hallucination is a false perception arising without an external stimulus: it is experienced as real and vivid, and occurring in external space (that is, "outside" the patient's head). In contrast, an illusion is a misinterpretation of a real external stimulus



Hierarchy of symptomatology of mental disorders

For a disturbed patient who is bewildered by his or her bizarre experiences, the interview may be a critical period and the doctor should not waste it

Summarising the findings

A bare diagnosis rarely does justice to the complexity of a presentation, nor does it provide an adequate guide to management. The formulation is a succinct summary of a patient's history, current circumstances, and main problems: it aims to set the diagnosis in context. It is particularly useful in conveying essential information, as when making a referral to specialist psychiatric services. An adequate referral to such services should include

- Description of the presenting complaint, its intensity and duration
- Relevant current and past medical history and medication
- Note of mental state examination
- Estimate of degree of urgency in terms of risk to the patient and others
- Indication of referer's expectations (assessment, advice, admission)
- The most urgent requests should be reinforced by telephone.

Role of voluntary organisations

Several local and national voluntary organisations are concerned with mental health. They may provide telephone advice or support, counselling, day centres, and volunteers or befriending services. Many patients benefit from the counselling or mutual support offered by such organisations, self help groups, and charities. These include patients with severe or protracted mental disorders and their carers, and many others who are distressed by unpleasant circumstances but are not suffering from a mental disorder and so do not require a referral to specialist mental health services.

The artwork is by Sandra Dionisi and reproduced with permission of the Stock Illustration Source. Data on the prevalence of psychiatric morbidity come from government departments, Mental Health Foundation, MIND, MORI, and SANE.

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The ABC of mental health is edited by Teifion Davies and T K J Craig, professor of community psychiatry, United Medical and Dental Schools, St Thomas's Hospital, London.

Example of referral letter to specialist psychiatric services

Mr A is a 35 year old married man with a three year history of severe depression controlled by antidepressant drugs. He was brought to my surgery by his brother, having tried to break into a church in response to grandiose religious delusions. He also showed irritable mood and pressure of speech suggesting a manic episode. He agrees to attend hospital today. Please assess urgently in view of the risk to himself and others.

Voluntary organisations offering general help for people with mental health problems

	Telephone No
Carers National Association	0171 490 8898
CarersLine	0345 573 369
Compassionate Friends (bereaved parents)	0117 953 9639
Cruse Bereavement line	0181 332 7227
MIND—National Association for Mental Health	0181 519 2122
National Association of Bereavement Services	0171 247 1080
National Schizophrenia Fellowship advice line	0181 974 6814
Relate National Office (marriage guidance)	0178 857 3241
SANE	0171 724 8000
Samaritans (24 hour emergency line)	0170 875 1111 0170 874 0000
Victim Support National Office	0171 735 9166
Women's Aid national helpline (domestic violence)	0117 963 3542

Further reading

Department of Health. *The health of the nation key area handbook: mental illness*. London: HMSO, 1994

Kendrick T, Tylee A, Freeling P. *The prevention of mental illness in primary care*. Cambridge: Cambridge University Press, 1996

Kopelman MD. Structured psychiatric interview: psychiatric history and assessment of the mental state. *Br J Hosp Med* 1994;52:93-8

Meltzer H, Gill B, Pettigrew M, Hinds K. *The prevalence of psychiatric morbidity among adults living in private households*. London: HMSO, 1995 (OPCS Surveys of Psychiatric Morbidity in Great Britain, Report 1)

Leaflets

From NHS Executive, Mental Illness, PO Box 643, Bristol BS99 1UU
Mental health: towards a better understanding
Mental health and older people
Can children and young people have mental health problems?

From Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG on various mental health topics

Any questions

Postoperative deep vein thrombosis in patient with hormone replacement implant

A 49 year old woman developed an above knee deep vein thrombosis 10 days after a hysterectomy and hormone replacement treatment implant. Should the implant be removed and should she have anticoagulant treatment?

This patient with deep vein thrombosis above the knee certainly requires anticoagulant treatment to prevent local extension and pulmonary embolus. A randomised double blind trial of heparin and warfarin versus warfarin alone in patients presenting with proximal vein thrombosis was terminated prematurely because of an excess of symptomatic events in the group receiving warfarin alone, emphasising the need for rapid anticoagulation where life is threatened by the risk of pulmonary thrombosis.[1]

In addition the adjusted odds ratio of thromboembolism in patients taking hormone replacement therapy (HRT) has been shown to be about three.[2] HRT will therefore increase the risk of further thromboembolism and the implant should be removed.

It is more difficult to be dogmatic about whether to prescribe HRT when the patient has recovered from surgery and the current episode of thromboembolism. Relevant factors would be the reason why the patient was prescribed HRT in the first place; whether there is any evidence of thrombophilia; whether the patient had any relevant past or family history to suggest thrombophilia or increased risk of thromboembolism; and whether any thromboprophylaxis was used at the time of surgery.[3] With the limited information available, however, I would be reluctant to advise the use of HRT in the longer term.

Michael de Swiet *is a consultant physician in London*

1 Brandjes DP, Heijboer H, Buller HR, *et al*. Acenocoumarol and heparin compared with acenocoumarol alone in the initial treatment of proximal vein thrombosis. *N Engl J Med* 1992;327:1485-9.
2 Daly E, Vessey MP, Hawkins MM, Carson JL, Gough P, Marsh S. Risk of venous thromboembolism in users of hormone replacement therapy. *Lancet* 1996;348: 977-80.
3 Vandenbroucke JJP, Helmerhost FM. Risk of venous thrombosis with hormone-replacement therapy. *Lancet* 1996;348:972.