Psychiatric Interview First Kit

Manual for Seminars in Psychiatry for English Speaking International and Czech Students

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KAROLINUM

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Preface

This manual is a tool for English speaking international students of medicine who study in the Czech Republic, providing information on how to interview and assess psychiatric patients in Czech language. It is also designed to be used as a tool for medical students who decide to do an internship at a psychiatric department abroad.

In the first part we focus on the way how a psychiatric assessment is carried out in English speaking countries.

In the second part we focus on a complex psychiatric assessment, using questions from Mini International Neuropsychiatric Interview (M.I.N.I.), Structured Clinical Interview SCID-CV. It also includes questions from practitioners based on their practical experience.

The manual is written for students at Faculty of Medicine in Pilsen, however, we hope that any student of medicine in the Czech Republic will find it useful.

Psychiatric Assessment in English Speaking Countries

This short text summarises how to carry out a standard psychiatric assessment when practicing in English speaking countries. This part should be read in conjunction with the other chapters.

Pre-assessment preparation

Review of the referral and collection of available information:
Patients can be referred to the assessment by their general practitioner, other medical specialists, social services, schools, courts, or other agencies. The psychiatrist should go carefully through the referral to understand the concerns of the referring professional.
Some patients come for their first assessment, however, many patients had been assessed before and there is usually a lot of information available on these patients in paper and (or) electronic notes. The assessor should make himself/herself familiar with the previous assessments, risk assessments, etc.

Start of the assessment

Introduction
The assessor has to introduce himself/herself in an appropriate and friendly manner to the patient and others (patient's relatives, advocates, other professionals) attending the assessment.

Limits of confidentiality
The information provided by the patient during the assessment is confidential, however, the confidentiality has its limits which are set by the local legal framework. The limits are specific for a particular country, nevertheless, if the information provided by the patient can result in a risk to other people, and to children and vulnerable adults in particular (for example, patient discloses that he has thoughts to kill his neighbour and has made a plan how to do it, or patient discloses that he was sexually abused by his father and the father has still access to children) there is usually a duty for the assessor to liaise with relevant agencies, like police or social services. The limits of confidentiality should be explained to the patient before the assessment starts.

Information sharing
The assessor should clarify with the patient if he/she is happy for the outcome of the assessment to be shared with his family members or friends, if they ask for any information related to the assessment.

History taking

Presenting complaint and history of presenting complaint
Circumstances leading to the assessment; patient's current symptoms, including mood symptoms, perceptual abnormalities, delusions, sleep problems, anxiety, appetite, weight loss or weight gain.
History of the current episode, possible psychosocial triggers for the episode, Current risks (suicidal ideation, recent sucidal behaviour and self-harm, risk of aggressive behaviour, self-neglect, etc.).

Family history
Details of parents (age, health, cause of death if deceased).
Number, age, and gender of siblings and children.

History of mental illness, suicide, alcoholism and drug dependence in the family.

Personal history
Circumstances of birth.
Postnatal development and developmental milestones.
Schooling (academic achievements, behavioural problems, relationships with schoolmates and staff, qualifications obtained).
Any history of bullying or abuse.
Employment history.
Relationship history – current relationship(s), if sexually active, any history of sexually transmitted disease (STD).
Hobbies.

Social circumstances
Housing (if flat or house, how many bedrooms, if privately owned or provided by a council or a housing association).
Who lives in the household.
Financial circumstances (sources of income, social benefits, debts).

Alcohol and illicit drug use
Alcohol consumption – how many units a week on average, pattern of driniking (binge drinking etc.), how frequently drunk, difficulties to stop, withdrawal symptoms (sweating, tremor).

Illicit drugs – what drugs and how frequently, in which form, withdrawal symptoms, previous and current treatments for addictions, rehab admissions, etc.

Past medical history
History of any serious physical illness.
Any chronic condition (diabetes, hypthyroidism, high blood pressure, epilepsy, etc.).
Any history of head injury, if unconscious or not.
Smoking status.
Contraception in women.

Forensic history
Any problems with police in the past.
If ever arrested, any charges or convictions.
Any custodial sentence, treatment order, fines, community service orders, etc.

Past psychiatric history
History of mental health problems, icluding age at first presentation and development of symptoms.
History of suicidal behaviour, self-harm, aggression to others.
History of contacts with mental health services.
Nature of interventions provided (counselling, psychotherapy, outpatient appointments with psychiatrist, home treatment input, etc.).
Previous psychiatric medications, response to them and side effects.
Dates of any previous psychiatric admissions, if admissions were voluntary or formal (under section of the Mental Health Act).

Current medication
List of all psychiatric and physical health medications, including doses.

Mental state examination
Appearance: (well kempt or unkempt, casually dressed or smartly dressed, etc.).
Behaviour and attitude: pleasant or hostile, eye contact, etc.
Orientation and cognition: orentation to time, place, and person, recordingobvious memory difficulties, concentration difficulties, etc.
Mood and affect: euthymic, elated, irritable, low in mood, etc.
Speech: rate, tone and volume.
Perception: (preceptual abnormalities e. g. hallucinations, pseudo-hallucinations, illusions, etc.).
Thought process: formal thought disorders like incoherence, tangential thinking, circumstancial thinking, etc.).

Thought content: overvalued ideas, delusions, intrusive thoughts.
Insight: full, partial, no insight.

Risk assessment
To evaluate:
Risk of suicide.
Risk of self-harm.
Risk to others.
Risk of self-neglect.
Physical health risks.
Vulnerability.

Risk management plan
How the identified risk will be managed (for example, referral to home treatment team, admission to psychiatric ward, etc.).

Working diagnosis
ICD 10 or DSM V working diagnoses.
Differential diagnosis.

RECORD OF A BRIEF PSYCHIATRIC ASSESSMENT: FICTIONAL EXAMPLE

Patient: Julia Bradbury

Date of birth: 27.06.1998

Address: Orchard Lane, Colchester, Essex, CO4 5SX

Introduction: I assessed Miss Bradbury at the Accidents & Emergency Department of Colchester General Hospital on 10th November 2018. She was brought to A&E Department by an ambulance at 16.30 after making an overdose of 22 tablets of sertraline 50mg. She was declared medically fit by A&E staff and I started the assessment at 18.10. Miss Bradbury was accompanied by her mother who was present during the interview.

Presenting complaint and history of presenting complaint
Miss Bradbury told me that she was feeling low in her mood for the last three to four months. She lacks energy and cannot concentrate properly. She works as an administrator and a week ago she was critisized by her supervisor for her poor performance. Subsequently she attended an appointment with her GP who signed her off work. She feels guilty about going off sick, and also worried about losing her job; she had a long period of sickness a year ago due to her previous episode of depression.
She has had problems with her sleep recently; she finds it difficult to get off to sleep and wakes up 4–5 times a night. She sleeps 4–5 hours a night in total. Her appetite is low and she has lost 4 kg over the last four months. She feels on and off anxious during the day, and when the anxiety comes she has difficulties to breath properly, has stomach ache and tingling feelings in her fingers. Her mood is low all the time, worst in the morning and slightly better in the evening. She feels frus-

trated and gets irritable and snappy towards her parents and her boyfriend.
Over the last several weeks thoughts of suicide started to come into her mind. She does not feel there is any point to live a life like this. She does not believe she will ever recover, and even if yes, these depressions will be coming again. These thoughts have escalated today, she took an overdose of sertraline, with intention to kill herself. She wanted to swallow all the tablets she had at home (sertraline and paracetamol) but after taking twenty two tablets of sertraline she started to feel guilty and called her mother who immediately called an ambulance.
Miss Bradbury denied hearing voices or having any other perceptual abnormalities. She also denied being persecuted, followed, watched or conspired against.

Psychiatric history
Miss Bradbury had one previous episode of depression. It started in October 2017 after break up with her long-term boyfriend. She was advised by her GP to go for counselling but she did not want to; she does not like to talk about her problems. She was started on sertraline 50 mg daily by her GP and her mood lifted after 4–5 weeks. She went back to work in January 2018. In May 2018 she stopped sertraline because she felt completely well. Since the depression came back her GP has re-started her on sertraline but it does not seem to work anymore, despite the increase of the dose four weeks ago.
Miss Bradbury denied any previous contact with mental health services.

Family history
Her mother is 49 years old and works as a primary school teacher. Her father is 50 years old and works as a manager for a local authority. She has one sibling, 21 years old sister, currently student at Manchester University. Her maternal grandmother suffered from depression and received treatment, she was admitted to hospital several times. There is no other history of mental illness or suicide in the family.