

CHAPTER 1

Mental Health Assessment

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OVERVIEW

- Mental health problems affect about a third of the adult population at any time, and all clinicians should be familiar with their recognition and initial assessment
- Mental health or psychiatric assessment follows a similar pattern to assessment in other clinical specialities: history of the presenting complaint, formal examination, investigation and diagnosis
- A full picture of the patient's problems may be built up over several interviews, and broadened to include collateral history from family and friends
- An initial interview with a distressed patient has important therapeutic value

Psychiatry in healthcare

Symptoms of mental disorder are common: at any time, about a third of the adult population reports suffering from distressing symptoms such as worry, sleep disturbance or irritability. According to the World Health Organization, mental disorders comprise five of the top 10 causes of years lived with disability, accounting for about 22% of the total disability worldwide. All healthcare professionals will encounter people experiencing mental health problems, so all clinicians require basic mental health skills (Box 1.1).

Psychiatry is the branch of medicine that deals with 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 regarding the role of psychiatrists (who are neither social workers nor gaolers) and myths about the practice of psychiatry.

The bulk of mild mental disorders has always been managed by family doctors. 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

Box 1.1 Prevalence of psychiatric morbidity

- **Mental symptoms:** 30% of adults experience worry, tension, irritability or sleep disturbance at any time
- **All mental disorders:** >20% of adults at any time suffer mental health problems; 25% 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:** >10% of adults have clinically important symptoms (about 5% generalised anxiety, 5–10% phobias, 1% each for obsessive–compulsive disorder, post-traumatic stress disorder and panic disorder)
- **Suicide:** rate in UK falling (now 8/100,000 per year) but rising elsewhere; 4000 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:** at least 2% 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

a short stay. Many former long-stay patients have been discharged to the community with varying degrees of support and supervision. This book will deal with the principles and practice of managing mental health problems.

Psychiatric assessment

There is a myth that psychiatric assessment differs from that in other medical specialties: it does not, it follows the familiar sequence of history, examination (both mental state and physical) and investigation, leading to differential diagnosis. Another myth holds that 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. 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 ascertained clearly.

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 (Boxes 1.2 and 1.3).

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 about matters of immediate concern to them and help to establish a rapport.

Closed questions

Specific closed questions (equivalent to the systematic inquiry of general medicine) should follow only when 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).

Box 1.2 Examples of useful open and closed questions

Open questions

- Is anything troubling you?
- Could you say a little more about it/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

- Is it like ..., or like ..., or like something else?

Box 1.3 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

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 these cases, 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 like ..., or ..., or something else?'

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

Initial assessment

The first and most important stage entails getting a clear account of current problems (presenting complaint and mental state), 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 patient's 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.

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 as they are associated with dangerousness. Patients who ask for complete 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.

Assessment of capacity

All patients must be assumed to have the capacity to make decisions for themselves about their care and treatment. Where there is doubt about this capacity, it must be assessed formally according to the Mental Capacity Act: this will be covered in more detail in Chapter 21.

Mental state examination

Whereas the history relates to events and experiences up to the present time, the mental state examination focuses on current symptoms and signs using closed questions. This bears direct analogy to 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 abnormal beliefs about family or neighbours (Box 1.4).

Physical examination and investigation

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 (Box 1.5) should be performed

Box 1.4 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 a level expected from his or her history?
- **Insight:** how does the patient explain or attribute his or her symptoms?

Box 1.5 Tests and investigations

- **Primary level:** full blood count (including red cell morphology); electrolytes; liver function tests; ECG; urine drug screen; breath alcohol
- **Secondary level:** chest X-ray; skull X-ray; renal function (e.g. creatinine clearance); blood chemistry (e.g. calcium, glucose, HbA_{1c}, thyroid function, drug levels, B₁₂, iron); serology (e.g. syphilis, hepatitis, HIV)
- **Tertiary level:** EEG; sleep EEG; CT and MR imaging; EMG

This approach clarifies the choice of psychiatric investigations

- Primary level tests should be considered for every patient and if not performed, the reasons for omission should be recorded
- Secondary and tertiary level tests should be performed only if indicated by the presentation, by other findings or on specialist advice, and the reasons for their performance recorded

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 (e.g. antidepressants, antipsychotics or lithium). An electrocardiogram should be considered before starting drugs with known cardiac effects, and body mass index (BMI) calculated before starting treatment with drugs that affect metabolism
- Concurrent medication (several drugs potentiate the cardiac effects of antidepressants and antipsychotics).

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. Whenever possible, a collateral history should be obtained from those who know the patient (family, friends or carers).

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

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.

Therapeutic importance 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 or checklist of symptoms.

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 nor measure it objectively but is still able to assess its significance. 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 (Box 1.6). In fact, psychiatric diagnoses based on current classification systems are highly reliable. It is true that

Box 1.6 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 as 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
- **Confusion** is a mild and transient state, in which there is fluctuation in level of consciousness, with impairment of attention and memory
- **Delirium** implies a more severe impairment of consciousness, usually of organic origin, with hallucinations and delusions

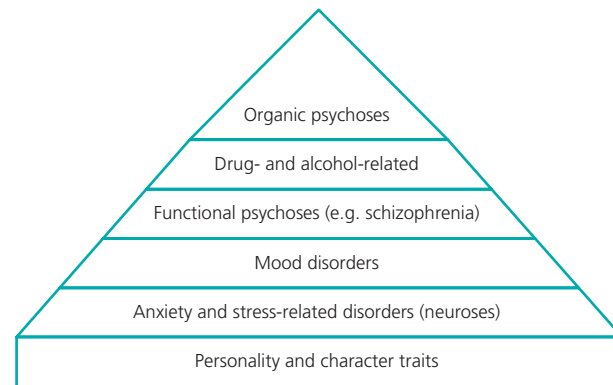


Figure 1.1 Diagnostic hierarchy of psychiatric disorders

- Each level *includes* all symptoms of all lower levels. A disorder may show any of the features of disorders below it at some time, but these are not characteristic of that disorder
- Each level *excludes* symptoms typical of higher levels
- In patients with a higher level disorder (such as schizophrenia) it may be important to treat 'lower level' symptoms (such as depression)
- A patient's enduring personality and character traits will modify his or her presentation of symptoms to healthcare services
- Coexisting physical disease and treatment will affect, and be affected by, the presentation of mental disorder.

there are no pathognomonic signs in psychiatry – that is, most psychiatric signs in isolation have low predictive validity, as 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 (Figure 1.1). 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 as they are at the foot of the hierarchy.

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 (Box 1.7). 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
- Findings of mental state examination
- Physical health and any drug treatment

Box 1.7 Example of an urgent referral to specialist psychiatric services

Mr A is a 35-year-old married man with a 3-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 that he was the new Christ. 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.

- Estimate of degree of urgency in terms of risk to the patient and others
- Indication of referrer's expectations (assessment, advice, admission)
- Very urgent requests may be brief but should be reinforced by telephone.

Consequences of mental disorder

Patients with mental disorders often suffer *stigma* – the experience of being discriminated against and rejected by others, and a consequent feeling of shame and disgrace. There may also be other serious consequences.

Mortality rates

Psychiatric disorders are associated with increased risk of death from all causes, and the all-cause standardised mortality ratio (SMR) among community psychiatric patients is about 1.6 (that is, about 1.6 times the rate in the general population). Mortality rates are highest among people suffering schizophrenia (SMR 1.76), men (SMR 2.24), and younger patients (SMR 8.82 for ages 14 to 24 years). So-called avoidable deaths are four times higher in patients with psychiatric diagnoses than in the general population. Some of this excess is due to suicide and violence, some to higher rates of respiratory, cardiac, and other diseases, and some to lack of appropriate healthcare. In some surveys, over 50% of patients smoked more than 15 cigarettes per day.

Disability rates

The World Health Organization estimates mental disorders to have a disproportionate effect on disability worldwide: mood disorders, schizophrenia and alcohol misuse cause about 20% of the days lived with disability. Depression alone contributes almost 5% of the global burden of disease, is worse in women and in developing countries, and reduces recovery from a range of physical illnesses.

Fitness to drive

A driver with a mental disorder has a slightly increased risk of being involved in a road traffic accident, with personality disorders, alcohol intoxication, and side effects of drug treatment accounting for most of the increase. Some disorders (such as schizophrenia, bipolar affective disorder) affect a driver's entitlement to hold

a driving licence, at least during the acute illness and for 6–12 months afterwards. For other disorders, the period of withdrawal of the licence will depend on the severity of the condition, and may be permanent in some cases (such as severe dementia). Patients have a duty to inform the licensing authority of any such disorder, and the doctor should do this where a patient is unable or unwilling to do so. Care should be taken to warn patients of potential side effects of drug treatment that might affect their driving.

Other aspects

Suffering from mental disorder might affect life insurance premiums, while being detained under the Mental Health Act may restrict a patient's voting rights. Local guidance should be sought in cases of doubt.

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.

Further information

The following organisations produce useful leaflets on various aspects of mental health

- Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG www.rcpsych.ac.uk/mentalhealthinformation.aspx
- The Mental Health Foundation www.mentalhealth.org.uk/information/mental-health-a-z/
- MIND www.mind.org.uk/Information/
- Rethink (National Schizophrenia Fellowship) www.rethink.org/about_mental_illness/index.html

Personal accounts of mental health problems

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