26.2 The psychiatric assessment of the medical pat

26.2 The psychiatric assessment of the medical patient 6447 Jane Walker, Roger Smyth, and Michael Sharpe

ESSENTIALS Medically ill patients often have psychiatric illness. Physicians can and should detect and diagnose these illnesses during their standard medical assessment. All that is required is knowledge of key ques- tions to ask patients, awareness of the clinical signs that may be ob- served, and an appreciation of the value of additional information from patient’s relatives, other clinicians, and the medical record. The aims are to detect and diagnose psychiatric disorders; as- sess the risk of self-harm or harm to others; establish the need for treatment or referral for a psychiatric opinion; provide the basis for clear and effective communication with a psychiatrist; and to com- municate to the patient that you are interested in all aspects of their suffering and thereby establish a clinically effective relationship with them. The sources of information are relevant history from the patient supplemented with specific questions; the clinician’s observation of the patient during the consultation; and relevant clinical records and reports from others (e.g. relatives, nursing staff). The minimum psychiatric assessment comprises the relevant his- tory and key questions based on the patient’s presenting complaint, history, and observation; observation of the patient during the con- sultation for signs of mental illness; composition of a list of any psy-

chotropic medication the patient is taking; an assessment (where appropriate) of risk of self-harm and harm to others; obtaining rele- vant information from relatives and other clinicians as needed; and the use (if required) of scales and tests, such as those for assessing cognitive impairment. Introduction A basic psychiatric assessment is essential for all medical patients. This is because mental illness is so common in patients presenting to physicians. In fact, rather than physical and mental illnesses af- fecting different populations of patients, as is often assumed, they tend to occur together in the same individuals. For example, as many as half of the patients admitted to a medical ward will have a mental illness, most commonly delirium, dementia, depression, anxiety, substance misuse, and somatic symptom disorder. All physicians therefore need to know how to recognize the symp- toms and signs of common mental illnesses. This process is often, but wrongly, thought to be distinct from the standard medical as- sessment, as well as being time-consuming and even risky. In fact, assessing patients for mental illness can be, and should be, an inte- gral part of the medical assessment. It need not be time-consuming and doing it will reduce rather than increase any risk the patient poses to themselves or others. The standard psychiatric assessment is traditionally divided into history taking and the 'mental state examination', which parallel medical history taking and physical examination. In practice, how- ever, the mental state examination is not a separate procedure done after taking the history, but is largely accomplished by observing the patient while taking the history. For example, a patient with depression may say that they feel low (history) and be observed (examination) to look tearful and to speak slowly while giving their history. The psychiatric assessment The psychiatric assessment has several aims and uses multiple sources of information. Aims These are to: • Detect and diagnose psychiatric disorders • Assess the risk of self-harm or harm to others • Establish the need for treatment or referral for a psychiatric opinion • Provide the basis for clear and effective communication with a psychiatrist • Communicate to the patient that you are interested in all aspects of their suffering and thereby establish a clinically effective rela- tionship with them Sources of information
These are: • Relevant history from the patient supplemented with specific questions 26.2 The psychiatric assessment of
the medical patient Jane Walker, Roger Smyth, and Michael Sharpe

 • The clinician's observation of the patient during the consultation • Relevant clinical records and reports from others (e.g. relatives, nursing staff) What to ask and look for The minimum psychiatric assessment comprises: (a) the relevant history and key questions based on the patient's presenting com- plaint, history and observation; (b) observation of the patient during the consultation for signs of mental illness; (c) a list of any psycho- tropic medication the patient is taking; (d) where appropriate, an assessment of risk of self-harm and harm to others; (e) relevant in- formation from relatives and other clinicians as needed; (f) use of scales and tests, such as those for assessing cognitive impairment, if required. The following sections summarize the core symptoms, signs, and additional information useful in detecting and diagnosing the psychiatric disorders most commonly seen in general medical practice. Depression Core symptoms of depression The two core symptoms of depression are pervasive low mood and loss of interest or pleasure (also called anhedonia). To detect low mood, ask the patient how they have been feeling. Be aware that when asked this, medically ill patients often assume they are being asked about their physical symptoms (e.g. pain) so a qualifier (e.g. 'how have you been feeling in yourself, how has your mood been?') may be required. It is also important to be aware that people use different words for low mood such as sad, unhappy, or down. If low mood is suspected, ask the patient just how low their mood has been, using their own

word for low mood, and then en- quire how much of the day and for how many days or weeks they have felt like that to find out how pervasive it has been. To detect anhedonia, find out if the patient has experienced a change in interest in or enjoyment of activities, ask about the things they usually enjoy doing and whether they are still able to get pleasure from these. For the person who is hospitalized or disabled, it is useful to focus on enjoyment of simple activities such as reading or visits from family or friends, and to ask whether they would like to be doing their usual activities if they were able. Box 26.2.1 suggests how to ask these questions. Signs of depression A patient with depression may appear to have lost interest in their appearance or self-care. They may move slowly, look downcast, and fail to make eye contact, have a sad facial expression or even cry. They may talk slowly with little intonation and with a negative, pes- simistic, or even hopeless content to their speech. Other sources of information An account of change in behaviour, including reduced activity and interest, from an informant is useful, as the patient may not always recognize the change in themselves. The medical records may indicate a history of depression, which is typically a relapsing disorder. There are many self-rated ques- tionnaires to determine the severity of depressive symptoms; a commonly used one, which can also be used as an initial screen for depression, is the PHQ-9 (Box 26.2.2). Mania Core symptoms of mania Manic episodes occur as part of bipolar disorder. The core symptoms of mania are abnormally elevated or irritable mood and greatly in- creased energy. These symptoms are severe enough to cause marked impairment in the patient’s ability to function at work or socially. To detect mania, recognize if the patient spontaneously reports their mood as unusually good or irritable, their energy as particularly high or their need for sleep greatly decreased. They may describe grandiose ideas (e.g. being able to control the weather) and unchar- acteristic behaviour such as spending beyond their means. Signs of mania A patient with mania may be distractible or restless, and be fidgeting or pacing about the room. They may appear ‘infectiously cheerful’ or easily irritated. Their behaviour may be overfamiliar and disinhib- ited, for example, sitting in the physician’s chair, playing with equip- ment, or making sexual suggestions to staff. They are likely to be talkative with rapid speech that is difficult to interrupt and may be fragmented in content. Other sources of information The patient’s account may be unreliable and an account from a close relative or friend is an essential source of information on both pre- vious history and recent behaviour. The medical records may indi- cate a history of bipolar disorder, which is a relapsing condition. Anxiety Patients are often anxious during medical consultations. Anxiety only becomes pathological when it is persistent and severe, or leads to avoidance of important activities or situations. Questions to ask about anxiety are suggested in Box 26.2.3. Core symptoms of anxiety The core symptoms of anxiety are feeling fearful, tense, or on edge. These symptoms may be due to a generalized anxiety disorder (when Box 26.2.1 Asking about depression ‘How would you describe your mood recently?’ Some patients find it difficult to describe their current mood. Ask them if they have felt down or low at all. Then ask how low—a scale of 1 to 10 can be helpful. Ask them for how long, and for how much of the time, has their mood been as low as this. ‘Can you still enjoy things you used to enjoy?’ Depressed patients typically describe lack of interest in previously en- joyed activities. If their medical condition is disabling, ask about non- physically demanding activities that they can still do (e.g. watching TV or reading) and whether they would like to be doing their usual activities if they were physically able.

26.2 The psychiatric assessment of the medical patient 6449 they are present most of the time), panic disorder (when they occur along with physical symptoms during discrete severe episodes), phobic disorder (when the anxiety occurs in specific situations that are often avoided) or obsessive-

compulsive disorder (when associ- ated with recurrent intrusive thoughts and compulsive actions). To detect an anxiety disorder, ask the patient how often they feel worried, anxious, or afraid. Find out whether the anxiety occurs in specific situations and whether it is preventing them from doing things, such as leaving the house, being able to relax, or attend hos- pital appointments. Ask if there is anything specific that they are concerned about and what they do when they become anxious. When asking about panic attacks enquire about severe anxiety that has a sudden onset with physical symptoms, often accompanied by a fear of collapse or even sudden death. Asking what the patient thinks about when they feel anxious may reveal obsessions, which are recurrent unwanted thoughts that pa- tients are often embarrassed to describe. In obsessive-compulsive disorder these occur along with compulsions; repetitive and illogical actions that relieve the anxiety and which can be elicited by asking what the patient does when they feel anxious. For example, a person with obsessional thoughts about spreading infections may compul- sively wash or disinfect their hands for hours on end. Signs of anxiety During the consultation, patients with anxiety may look tense, sweaty, or shaky. They may repeat questions and seem preoccu- pied with the worst outcomes. If they have a panic attack during the consultation, they will show a sudden onset of anxiety, often with shaking and hyperventilation, that subsides rapidly. Anxiety related to a phobia, for example, of needles, may manifest during the con- sultation at the mention of these. Some patients have an anxious pre- occupation with having a serious illness (health anxiety) and may repeatedly request reassurance or investigations for this. Finally, evi- dence of compulsions such as handwashing may be seen on physical examination as red dry hands. Other sources of information An account from a close relative is useful, particularly in quantifying the degree of avoidance. The medical records may reveal a history of anxiety. Frequent attendance at the hospital or clinic may indicate anxiety about having a serious illness such as cancer. A self-rated questionnaire, such as the GAD-7, can be used to determine the se- verity of generalized anxiety symptoms (Box 26.2.4). Substance misuse Excessive and often harmful use of alcohol is common in medical patients. Some patients misuse other drugs both prescribed (such as opiates) and illicit (such as so-called legal highs). It is therefore useful to routinely ask patients about their alcohol and drug intake, Box 26.2.2 The 9-item Patient Health Questionnaire (PHQ-9) Over the last week how often have you been bothered by the following problems? Not at all (0) Several days (1) More than half the days (2) Nearly every day (3) Little interest or pleasure in doing things □ □ □ □ Feeling down, depressed, or hopeless □ □ □ □ Trouble falling or staying asleep, or sleeping too much □ □ □ □ Feeling tired or having little energy □ □ □ □ Poor appetite or overeating □ □ □ □ Feeling bad about yourself, or that you are a failure, or have let yourself or your family down □ □ □ □ Trouble concentrating on things, such as reading the newspaper or watching television □ □ □ □ Moving or speaking so slowly that other people have noticed. Or the opposite—being so fidgety and restless that you have been moving around a lot more than usual □ □ □ □ Thoughts that you would be better off dead, or of hurting yourself in some way □ □ □ □ Scores of 10, 15, and 20 are the cut-off points for moderate, moderately severe, and severe depression, respectively Box 26.2.3 Asking about anxiety ‘Recently, have you been feeling more anxious than usual?’ If yes, ask the patient to describe how severe the anxiety is and how often it is present. Also ask when the symptoms began and what was happening at that time. ‘Do any particular places or situations make you anxious?’ Establish first whether the anxiety is continual or episodic. If the latter, enquire about those environments or situations that cause the exacerba- tions. This may indicate specific phobias. ‘Have you ever had a panic attack?’ Ask the patient to describe to you what their attacks of anxiety are like. A panic attack is sudden in onset with gradual resolution over the subse- quent 30 minutes. The patient experiences a sensation of extreme anx- iety and fear, usually accompanied

by physical manifestations of anxiety such as hyperventilation (which may induce paraesthesia), dizziness, sweating, and palpitations.

section 26 Psychiatric and drug-related disorders 6450 especially when the reason they have presented, such as an accident or liver disease, is known to be associated. Core symptoms of substance misuse To detect substance misuse, ask the patient whether they drink alcohol and whether they take any drugs, other than the ones prescribed for them. To get an estimate of alcohol intake, ask the patient to go through what they have drunk each day for the last week, noting binges as well as a steady daily intake. The core symptoms of alcohol use disorder are drinking excessively despite negative consequences, unsuccessful at- tempts to cut down intake, cravings, tolerance, and drinking to prevent withdrawal symptoms. Patients with a history of daily or near-daily drinking, with morning drinking, and those regularly drinking more than 15 units of alcohol daily should be considered at high risk of with- drawal symptoms and delirium tremens. Signs of substance misuse There may be obvious signs such as smelling of alcohol, appearing in- toxicated or even carrying alcohol (the clink of bottles in the carrier bag) or other drugs into the hospital. Patients may also show signs of alcohol withdrawal such as shaking, sweating, hallucinations, and seizures. Physical examination may reveal other relevant signs such as evidence of frequent falls, liver disease, or needle marks. Other sources of information People notoriously underestimate their alcohol consumption and an account from an informant is valuable corroboration. Medical re- cords may indicate diagnoses suggestive of alcohol or drug induced harm such as liver disease. The four-item CAGE questionnaire can be used as a screen for problem drinking. In the acute and emer- gency setting, an important issue is the identification of patients at risk of the development of alcohol withdrawal; this is especially likely in those who the final answer yes to the last question of the CAGE—drinking in the morning to prevent withdrawal symptoms. The CAGE questions are listed in Box 26.2.5. Psychosis These include both the so-called ‘functional’ psychoses (schizo- phrenia, acute psychotic episodes, delusional disorder and severe depression or mania) and in the ‘organic’ psychoses (in delirium, dementia, and states resulting from brain injury and substance misuse). In medical contexts, new onset psychotic phenomena are more likely to be a symptom of organic disturbance of brain func- tion, particularly delirium, dementia, or drug and alcohol intoxica- tion or withdrawal, than a functional psychosis. Core symptoms of psychosis The core symptoms of psychosis are delusions and hallucinations. Delusions are fixed false beliefs that often have a bizarre quality, such as thinking the nurses are secret agents. Hallucinations are false experiences (although they seem real and to have come from the outside world to the patient), in any sensory modality, such as seeing rats that are not there or hearing voices when no one is present. It is neither necessary nor appropriate to do routine screening for psychotic phenomena. Asking medical patients about ‘voices’ or ‘odd ideas’ is unlikely to yield much useful in- formation and may perplex them. However, if the history, obser- vation, or other sources of information suggests such symptoms, they should be carefully enquired after. Questions to ask are listed in Box 26.2.6. Signs of psychosis A patient who has a psychosis may appear to be responding to hal- lucinations, for example, looking at places in the room where there are no people or movements or talking to people who are not there. They may behave bizarrely or appear frightened because of their de- lusional beliefs. Signs suggesting an organic psychosis are impaired alertness, visual hallucinations, and a fluctuating mental state. Box 26.2.4 The 7-item Generalized Anxiety Questionnaire (GAD-7) Over the last week how often have you been bothered by the following problems? Not at all (0) Several days (1) More than half the days (2) Nearly every day (3) Feeling nervous, anxious, or on edge □ □ □ □ Not being able to stop or

control worrying □ □ □ □ Worrying too much about different things □ □ □ □ Trouble relaxing □ □ □ □ Being so restless it is hard to sit still □ □ □ □ Becoming easily annoyed or irritable □ □ □ □ Feeling afraid as if something awful might happen □ □ □ □ Scores of 5, 10, and 15 are the cut-off points for mild, moderate, and severe anxiety respectively Box 26.2.5 The CAGE questionnaire C: Have you ever felt you should Cut back on your drinking? A: Has anyone ever Annoyed you by criticizing your drinking? G: Have you ever felt Guilty about your drinking? E: Have you ever had a drink early in the morning as an Eye-opener? More than two positive responses suggests possible at-risk drinking and should prompt further assessment. N.B. The 'Cage +2' adds two additional questions:

1. What is the most alcohol you have drunk in a single day?
2. What is the most alcohol you have drunk in a single week?

26.2 The psychiatric assessment of the medical patient 6451 Other sources of information History from an informant is crucial. While psychotic illnesses are very variable in presentation, within an individual patient each epi- sode tends to be similar. Therefore asking what symptoms occurred during the most recent relapse and whether similar symptoms are present now is a useful method of enquiry. Medical records may in- dicate a previous history of psychotic illness or the prescription of antipsychotic drugs. Cognitive impairment Impairment in cognitive function is very common in medical pa- tients. The chronic form called dementia becomes more preva- lent with increasing age. The acute form called delirium (or acute confusional state) is a common complication of many medical dis- orders and is especially common in those with some pre-existing cognitive impairment. Core symptoms of cognitive impairment The core symptom of cognitive impairment is the inability to process information. This may manifest as failing memory or the inability to complete simple tasks such as making a cup of tea. Patients with cognitive impairment may also be unable to behave in a socially ap- propriate way. Given the high frequency of, and risk resulting from, undetected cognitive impairment it should be actively considered in all elderly patients. At a minimum, patients should be asked simple questions to determine their orientation to time, place, and person. Signs of cognitive impairment The patient who is cognitively impaired may appear confused and may fail to understand the nature of the consultation or to recall previously provided information. The delirious patient may appear drowsy and have an obviously reduced conscious level. It is im- portant to be aware that a polished social façade may mask signifi- cant cognitive deficits. Other sources of information History from family and friends, carers, or other professionals is cru- cial to both determining the severity of the impairment and whether it is of new onset. It also allows the clinicians to establish how well the patient functions at home when they are unable to give an accurate history themselves. Medical records are often useful in determining the duration of any impairment. The Abbreviated Mental Test (AMT) is a short 10-item bedside screening test for cognitive im- pairment (Box 26.2.7). For practical purposes, however, how much any cognitive impairment affects the patient's real-world function is often more important than absolute scores in standardized tests. For patients found to have cognitive impairment, a more detailed assessment may be required. This should include an assessment of their current functional level, a review of their previous cognitive state and function and the likely cause for any decline. Many bedside tests of cognitive function are available such as the 30-item Montreal Cognitive assessment (MoCA). Eating disorders The most common eating disorders are anorexia nervosa and bulimia nervosa. In both of these conditions, the patient strives for weight control; in the former, they are notably thin and in the latter, they are not. Core symptoms of eating disorders The core

symptom of anorexia nervosa is an intense fear of becoming fat, which leads to severe dietary restriction and low body weight. The core symptoms of bulimia nervosa are recurrent episodes of binge eating with compensatory behaviours intended to prevent weight gain. These symptoms may be detected by asking the patient in detail about their dietary intake, use of laxatives or diuretics and daily exercise regimen, as well as their thoughts about their body size and shape. Signs of eating disorders Low body weight is the most obvious sign of anorexia nervosa. Other signs of eating disorders include eroded dental enamel and calluses on the knuckles (Russell's sign) from self-induced vomiting, lanugo hair, and dry skin. Other sources of information A history from the patient's general practitioner and family is essen- tial. Nursing staff may note that the patient repeatedly refuses food while in hospital, makes trips to the bathroom immediately after eating, or is seen vomiting or hiding vomit. Medical records may indicate complications of eating disorders, such as recurrent elec- trolyte disturbances. Box 26.2.6 Asking about psychotic symptoms 'Have you heard voices when there was no one about?' Hallucinations can occur in any modality of sensation, however auditory hallucinations are characteristic of schizophrenia and similar illnesses. They are experienced as coming from external space rather than 'inside my head'. Their quality, content, and degree of associated distress should be explored. 'Do you ever feel that people are talking about you, or spying on you, or trying to harm you?' Delusions are another core feature of psychotic illnesses and can have a wide variety of contents. Referential and persecutory delusions are com- monly seen. The content of the belief and the patient's rationale for be- lieving it should be explored. A characteristic of true delusions is that they are rigidly held and not amenable to rational argument. Box 26.2.7 The Abbreviated Mental Test (AMT) What is your age? (1 point) What is the time to the nearest hour? (1 point) Give the patient an address, and ask him or her to repeat it at the end of the test. (1 point) (e.g. 42 West Street) What is the year? (1 point) What is the name of this place? (1 point) Can the patient recognize two persons (e.g. doctor, nurse)? (1 point) What is your date of birth? (day and month sufficient) (1 point) In what year was the 9–11 terrorist attack? Or year of the First World War? (1 point) Name the present prime minister or president of the United States. (1 point) Count backwards from 10 down to 1. (1 point) A score of 7 or less suggests some cognitive impairment

section 26 Psychiatric and drug-related disorders 6452 Stress-related disorders Stress-related disorders, by definition, occur in response to a trau- matic or stressful event. These include acute stress disorder and adjustment disorder in which the stressor is current, and post- traumatic stress disorder. The latter may be less obvious and should be suspected when the patient has been or is subject to a major stressor such as a severe car accident. Core symptoms of stress-related disorders The core symptoms of post-traumatic stress disorder (PTSD) are recurrent, intrusive memories of the event, including 'flashbacks', distressing event-related dreams, problems with concentration and hypervigilance, and significant avoidance of things that remind the patient of the event. To detect these symptoms, ask how the patient is coping since the event, whether they are sleeping well and how they are generally feeling about it. Signs of stress-related disorders Patients with PTSD may go to great lengths to avoid distressing memories, for example, driving miles out of their way to avoid the site of a car crash. They may find it difficult to concentrate on the consultation or be noted to have repeated nightmares. Other sources of information The medical records may indicate the nature of the stressor. The timing from the date of the event is important in determining the type of stress-related disorder and therefore appropriate treatment. Personality disorders The core features of personality disorders are extreme and maladap- tive personality traits that cause difficulty or distress to the person themselves or to others. Physicians

may be alerted to the possible diagnosis of a personality disorder in patients who recurrently self-harm, show extreme responses to events, or have unusual ways of re- lating to clinical staff. The diagnosis of personality disorder requires that the patient have a long history of similar behaviours and the exclusion of other psychiatric diagnoses. It therefore requires a thor- ough psychiatric assessment. Somatic symptom disorder The core feature of somatic symptom disorder is concern about physical symptoms that appears to be out of proportion to the se- verity of any associated disease. The concern may manifest as dis- proportionate preoccupation, distress, and disability. The symptoms may be medically unexplained, but somatic symptom disorder also co-occurs with medical disease. Physicians may be alerted to the possible diagnosis of severe somatic symptom disorder during the physical examination by multiple operation scars and from the med- ical records by a history of frequent attendance at medical services and numerous negative (and often repeated) investigations. Severe somatic symptom disorder can be difficult to manage and requires collaboration between all the physicians involved in the patient's care; referral to liaison psychiatry can be helpful in confirming the diagnosis and helping to construct a management plan. Risk of self-harm and suicide When to ask While it would not be appropriate to ask everyone about suicidal in- tent or thoughts of self-harm, this should always be done when there is evidence of depression, and especially when the patient has ex- pressed thoughts that they would be better off dead, feelings of hope- lessness, or when there is a history of self-harm. It is important to be aware that sensitive enquiry will not 'put the idea into the patient's head' or increase the risk of self-harm or suicide. Rather it will pro- vide an opportunity to address and consequently reduce the risk. How to ask It may seem intrusive to ask a patient directly about suicidal thoughts, hence it is often best to ask a graded series of questions, starting with 'How do you feel about the future?' Then 'Has it ever got so bad you thought life is not worth living?', then 'Have you ever thought about ending your life?' and then, if appropriate, 'What plans have you made?' Examples of questions are shown in Box 26.2.8. Signs of previous self-harm Physical examination may reveal marks or scars from previous self- inflicted injuries. Other sources of information Medical records may reveal a history of self-harm. An account from a close relative is valuable is learning about recent attempts of pre- parations. This may include hoarding pills or searching the internet about how to commit suicide. Box 26.2.8 Asking about suicidal ideas 'How do you feel about the future?' 'Do you ever feel hopeless about it?' Most patients will retain a degree of optimism about eventual improve- ment or recovery, even with significant medical illness. A sense of hope- lessness towards the future can be associated with depressed mood and suicidal thoughts, and should prompt further exploration. 'Have you ever felt that it hasn't worth going on, or that life was not worth living?' These thoughts can develop from a sense of hopelessness and are often associated with thoughts of death which may be passive (e.g. 'it would be nice to go to sleep and not wake up'), or active—where the patient considers taking steps themselves to end their life. 'Have you ever thought about ending your life?' If the patient answers yes, enquire about the frequency of these thoughts—are they fleeting and rapidly dismissed, or more prolonged? Are they becoming more common? 'Have you thought about how you would do it?' Explore which methods the patient has considered and what prepar- ations they have made. Violent suicide methods (e.g. hanging, jumping, firearms) are particularly concerning. Repeated visualization of the act of suicide is associated with increased risk. 'Have you ever tried to take your own life?' A history of previous suicidal actions increases the current risk. A recent concealed attempt (e.g. overdose) may necessitate additional medical assessment.

 Risk to others When to ask It is important to consider risk to others when the patient has delusional beliefs that other people are

trying to harm them in some way, are not who they say they are, or are trying in some way to thwart them. Patients with depression are at much greater risk to themselves than to others. However, women with postnatal depression and patients with particu- larly dependent relationships may have thoughts of ending the lives of their loved ones as well as their own. Patients with personality disorders, in particular antisocial personality disorder, may sometimes pose a risk to others and if threats are made, these should be explored. How to ask As with suicidal thoughts, a graded approach is usually best. Prefacing questions with an acknowledgement of the patient’s situation, such as, ‘this must be very difficult for you’ can be followed by, ‘sometimes in this kind of situation people start to think about how they could harm the people that are persecuting them’ or ‘sometimes when people feel this bad and they are thinking about ending their lives, they also think about ending their families’ lives’, have you had any thoughts like that?’ When to seek help If you have any concerns that the patient might pose a risk to them- selves or to others, even if the patient ‘says the right things’, it is essen- tial to seek a psychiatric opinion. Psychotropic drugs Many patients are taking psychotropic drugs. As well as asking the patient about these, it is important to clarify from records or their usual clinician, what they are prescribed for their psychi- atric condition. Remember to ask about depot medications; these are long acting antipsychotic drugs, often given by fortnightly injection. Also enquire about dosages and pick-up routines for substitute drugs prescribed in addictions—from which pharma- cist are they dispensed, has the prescription been stopped while the patient is in hospital, and does the patient take all of their prescription. FURTHER READING American Psychiatric Association (2013). Diagnostic and statis- tical manual of mental disorders, 5th edition (DSM-5). American Psychiatric Press, Washington, D.C. Kroenke K, et al. (2010). The patient health questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. Gen Hosp Psychiatry, 32, 345–59. Nasreddine ZS, et al. (2005). The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild cognitive impairment. J Am Geriatr Soc, 53, 695–9. Trzepacz PT, Baker RW (1993). The psychiatric mental status examina- tion. Oxford University Press, New York, NY.

Revision #1
Created 2026-01-22 16:43:54 UTC by Omar Ayman
Updated 2026-01-22 16:43:54 UTC by Omar Ayman