

Year 5 Psychiatry

Undergraduate Handbook 2021



THE UNIVERSITY OF
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Te Whare Wananga o Tamaki Makaurau
NEW ZEALAND

**MEDICAL AND
HEALTH SCIENCES**
SCHOOL OF MEDICINE

What is psychiatry?

Psychiatry is the medical specialty that deals with the study and treatment of mental illnesses and of other disorders, both behavioural and physical, in which psychological factors are important as causes or clinical features. The majority of people with mental disorders will never be seen by a psychiatrist or mental health service; some never come to clinical attention, while others present to GPs or hospital specialists, sometimes with somatic symptoms.

What are the different areas of psychiatry?

In addition to general adult psychiatry, this discipline includes a number of sub-specialties including:

- Child and adolescent psychiatry, where the focus is on mental disorders in young people (under 18)
- Old age psychiatry, the 65+ age group
- Forensic psychiatry, the interface between psychiatry and the law
- Consultation-liaison psychiatry, typically practiced in general hospital settings, addresses the overlap between mental and physical illness
- Neuropsychiatry, disorders of brain function that manifest as symptoms of mental illness
- Addiction psychiatry, where the focus is on harmful substance use and the relationship this has with mental illness

There are other sub-fields of psychiatry that include eating disorders, intellectual disability, etc.

During this rotation you will learn core skills that you can use in other medical settings, both in hospital and in the community. You will learn that mental illness is a significant public health issue that affects many people, their families, their communities and society.

Mental disorders are common

There is thus increasing awareness of psychiatric disorder prevalence and its contribution to disability and mortality. WHO studies (1990) show that 11% of the total global burden of human disease was referable to mental illness. In 2020, this is expected to rise to 15%. It is estimated that five of the ten leading causes of disability are psychiatric (unipolar depression, alcohol misuse, bipolar affective disorder, schizophrenia, obsessive compulsive disorder). Mental illnesses are estimated to account for 28% of total years lived with disability. Community studies in New Zealand and overseas have shown that the six month prevalence of mental disorders is 25% and

8-9% of the population have significant disability due to psychiatric illness.

On a personal level many of us have friends or family who have received treatment for a psychiatric disorder. You may know someone who has tragically taken his or her own life. In psychiatry, we seek to understand and modify factors, including undiagnosed psychiatric illness, that may influence a person's pathway to suicide.

Mental health services

The specialist mental health services in any country have limited capacity, and treat only a small proportion of the people with psychiatric disorder. For example, the aim of the New Zealand mental health services is to treat only those 3% of people who have the most severe forms of illness. Most people with mental disorders who seek medical help will thus present to non-psychiatrists, especially general practitioners. This means all medical practitioners should be able to recognise the manifestations of psychiatric illness, initiate a management plan and to refer appropriately when the condition is outside their level of expertise.

Mental health has been identified as a priority area by government for the development of services and for research. Services are becoming progressively more community based and generally involve multidisciplinary teams of professionals with different backgrounds offering a range of interventions from pharmacological management through to group psychotherapy. Consumer groups of patients and carers are becoming vocal advocates for changes to services and for greater recognition of mental health issues. Research ranges across fields as diverse as molecular biology and sociology and conditions are often investigated at a number of different levels. Thus, research into the brain mechanisms underlying the major psychiatric conditions proceeds in parallel with studies of the type and combination of psychotherapeutic intervention best suited for the treatment of the same conditions.

What are our roles as doctors?

There is still considerable stigma associated with having a psychiatric diagnosis. As doctors we should be prepared to advocate for those with mental illness, as this stigma may discourage people from seeking treatment. It is also our job as doctors to ensure that when working with patients we don't see the mind and the body as separate. Patients with mental disorders have high rates of physical health problems, and those with chronic medical conditions have high rates of psychiatric disorder; whichever way you look at it, such comorbidity tends to adversely affect clinical outcome.

It should also be recognised that doctors themselves are at high risk of mental illness. Alcohol and drug problems, depression and dementia account for a number of the cases that come to the attention of the Medical Council. Sensitivity and support for our colleagues and awareness of our own vulnerabilities are essential aspects of becoming an effective professional.

Psychiatry is a complex specialty and may seem bewildering when first encountered as a student. It rewards practitioners able to tolerate uncertainty, and who have a capacity for empathy, awareness of interpersonal boundaries, broad intellectual interests and who appreciate the range of behaviours and emotions associated with the human condition.

Some of the situations you encounter in your placements may be challenging or distressing. Please discuss any concerns you have during your attachment with your supervising consultant, registrar, or cohort tutor.

Cover, pages 6-7, 16 and 17:

Photography by Jill Masters
and David Menkes



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Learning outcomes in psychiatry

By the end of the Year 5 clinical attachment students should be able to:

Domain: Applied Science for Medicine

1. Clinical knowledge

- Explain the key diagnostic features, aetiology and principles of management of patients with common psychiatric problems.
- Explain the concept of recovery in mental health.
- Describe the basic principles of clinical psychopharmacology.
- Describe the principles of psychotherapy and other psychosocial interventions in psychiatry.
- Integrate with clinical practice their prior knowledge of the normal structure, function and development of the human body and mind at all stages of life, the factors that may disturb these, and the interactions between body and mind.
- Apply scientific principles, research methodologies and evidence to improve practice and the mental health of individuals and communities.

Domain: Clinical and Communication skills

2. Patient assessment and management

- Assess patients presenting with a range of psychiatric problems across different developmental stages e.g. childhood/ adolescence, adulthood, old age.
- Demonstrate competence in eliciting a psychiatric history and performing a mental state examination.
- Present findings of a psychiatric assessment in a logical, coherent manner, both written and orally.
- Synthesise and integrate information to formulate differential diagnoses.

3. Clinical decision-making

- Formulate a multi-axial diagnosis using DSM or ICD.
- Develop a biopsychosocial management plan.
- Assess safety risks.
- Identify various risks to be managed and include these in a plan.

4. Communication with patients and families

- Inform patients and their families, as appropriate, regarding assessment findings and treatment options.
- Communicate with patients and families using a clear and sensitive approach.

Domain: Personal and Professional skills

5. Professional qualities

- Demonstrate effective time management and punctuality.
- Consider ethical implications during patient encounters and clinical decision-making.
- Demonstrate awareness of the importance and role of good doctor-patient relationships.
- Demonstrate capacity for critical thinking and constructive self-criticism.
- Use a developmental approach to clinical problems.

6. Engagement in team

- Demonstrate a collaborative approach in clinical environments
- Ability to engage with staff from the multidisciplinary team, and from the public, community and non-governmental sectors.

7. Health and Wellbeing

- Be able to apply a range of approaches to maintain psychological, physical and overall well-being of self and others.
- Recognise one's own limits.
- Demonstrate reflective practice.

Domain: Hauora Māori

8. Critical reflection

- Identify key Māori health issues and explain approaches to addressing the issues.
- Identify the strengths and areas for improvement in your communication and clinical skills when dealing with Māori patients.
- Develop an appropriate management plan for the specific needs of the Māori patient.

9. Commitment to equity

- Propose strategies to address issues of ethnic inequality.
- Develop an appropriate management plan for the Māori patient and family.
- Participate in or observe a whānau meeting.

10. Cultural safety

- Engage appropriately in interactions with Māori individuals, whānau and communities.
- Identify areas for improvement in communication and clinical skills when dealing with Māori families.

Domain: Population Health

11. Disease prevention

- Identify major threats to mental health and critique trends in healthcare delivery in New Zealand and internationally.
- Suggest improvements that may lead to better collaboration among mental health agencies.
- Appraise the organisation of health services for patients with psychiatric problems.
- Appraise the importance of the family and wider environment on patients.

12. Health promotion

- Apply the principles of mental health promotion, population screening and disease management involving individuals and populations to a range of healthcare settings.

Clinical attachment

Your clinical attachment is for a period of 6 weeks usually from 0830-1700hrs (check with your individual unit). While in this attachment you will be assigned to a consultant psychiatrist, and also attend a seminar programme involving small group teaching covering basic topics in psychiatry, organised by your cohort tutor. Details of the programme, topics and timing will be advised separately. You will have regular group sessions with your cohort tutor who is there to coordinate the teaching at the site, to answer questions and to help you to ensure you get the training you need. Alongside the face to face seminar programme, there are e-learning resources for you to complete via the MBChB portal under MyPsychiatry.

If you have questions or problems during your attachment which cannot be answered by your consultant, please contact your cohort tutor:

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Cohort Tutors can advise on the Course Administrator in your location.

Overall administrator for the course:

Saira Khan

Email: s.khan@auckland.ac.nz

Year 5 Academic Programme Coordinator:

A/Prof David Menkes

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Please remember:

- Dress responsibly as a health professional.
- Ask politely, smile, make good eye contact and you are more likely to be successful in your interactions with patients and staff.
- Always ask patients whether they are willing for you to be involved.
- Be proactive in asking to join consultations
- Respect patient confidentiality at all times.
- Use computer privileges to access personal health information relevant to your case(s) only.
- Advise your consultant in advance about any absences due to approved leave or illness.

Your time in Psychiatry is designed to:

- Acquaint you with a variety of psychiatric disorders.
- Accustom you to interviewing patients with psychiatric disorder.
- Develop your skills in performing the mental state examination.
- Enable you to observe and, where appropriate, join mental health professionals in their work.
- Give you an opportunity to formulate the role of biological, psychological and social factors in the development and experience of psychiatric illness.



Māori and mental health

Despite many service improvements in recent years, Māori still tend to access mental health services at a later stage of illness and with more severe symptoms. Therefore, improving the responsiveness of services to Māori continues to be critical. The Treaty of Waitangi requires that all health services follow key principles of partnership, participation, and protection with Māori patients. In practice this means developing services which respect and welcome Māori approaches to health and illness, so it is important that students understand these in their placements.

In 1982 academic psychiatrist, Professor Sir Mason Durie presented his Te Whare Tapa Whā (Four walls of the house) model of a Māori perspective of health. He noted that the four walls are all needed to provide symmetry and strength, representative of good health. These walls together are seen as enhancing spiritual wellbeing, consolidating identity links with one's tupuna (ancestors) and whānau, and strengthening links with culture and the land.

In brief, the four walls are:

Taha Tinana

Physical well-being, the capacity to develop and grow

Taha Wairua

The spiritual dimension, including the capacity for faith

Taha Whānau

The importance of the extended family, the capacity to belong and share.

Taha Hinengaro

Mental health and the capacity to communicate, to think and to feel.

None of these walls is seen in isolation, in particular there is no thought of isolation of body from mind.

Services with Māori patients normally employ these models either implicitly or explicitly. In line with psychiatry learning objectives, students need to understand how the models are used and be able to discuss mental illness and recovery for Māori patients in this context.

For further information on Whare Tapa Whā model, see:

www.health.govt.nz

Other models have also developed to help staff seeing other groups, for example, the Fonofale model (Samoan) and Fonua model (Tongan).



Hints for starting Psychiatry

Week 1

Get acclimatised. Acquaint yourself with the MyPsychiatry website which is available via the MBChB portal. Introduce yourself to staff, find out the protocols and habits that you will need to follow. Observe interviews of at least 2 or 3 patients every day remembering to introduce yourself clearly, and to ask for permission to be present. Patients may like a chance to talk about the impact of their illness on their family, or the advantages and disadvantages of their medication, or what they think about medical education.

Familiarise yourself with how to take a history, describing features of the mental state exam and start covering the core modules that are found on MyPsychiatry. In other words, use this week to find your feet. Find out when and how you can present your CAT to your consultant, team, or wider audience (e.g. Waikato). Also start preparing for the mid-way and end of run of assessments and start booking in times to meet with your consultant supervisor.

Weeks 2 and 3

Increase the time spent with patients. By the end of the third week you should be able to cover presenting symptoms, past history, family history and personal history without exhausting either yourself or your patient. Aim to start interviewing patients by yourself by the end of Week 3.

Now that you are more part of your work environment, you should be able to find opportunities to go with multidisciplinary members of staff and watch them at work. Wherever possible, discuss cases. You should now be organising your observations into mental state examinations more confidently. Arrange 1 evening on-call work per week with an on-call registrar. Acute psychiatry is a different world, and you will learn much from it.

Start writing your case history. Follow the template found later in this guide. Ask your consultant and or registrar to critique it.

Where possible, ask to practice doing mental state examinations after seeing cases. Consider typing up notes as an opportunity to have your mental state examinations reviewed by consultants.

Do your first (formative) mini-CEX and discuss with your consultant your performance for the past 2-3 weeks and bring your Clinical Experience Checklist along with you. If you have difficulties, this is the best time to address them. You should all be able to pass your run, and we are keen to help you do this.

Week 4

This is the week to broaden your clinical experience – perhaps with a home visit if you have not yet done one, or with taking part in a family meeting.

Try to increase your knowledge of multicultural issues this week. Widen your experiences by swapping with a peer from another service for a day, or participate in an outpatient clinic. Seek permission from the consultants involved before you swap with someone from another service.

Weeks 5 and 6

Consolidate your experiences in all areas. Complete your Clinical Experience Checklist. Continue to schedule weekly on-call experiences. Present your CAT. Finalise your case history and upload via Turnitin before the deadline and organise a summative mini-CEX with your supervisor. Also, the Clinical Supervisor Report will require completion by the end of your attachment. Finally, submit feedback forms for both MyPsychiatry (hyperlink will be emailed to you and also available on the site) and also for the attachment. Submit original copies of your assessments to your cohort administrator while retaining photocopies for your own reference.

Assessment/course requirements

Clinical experience checklist

You are expected to keep a log of your clinical experience. You have been provided with guidance about the types of experience necessary to meet learning objectives in psychiatry. Please talk to your registrar and consultant about your activities and use the log to focus your discussions, especially if you are aware that covering all the experiences could be a problem. During your clinical attachment, you should aim to see as wide a variety of patients as possible. If your clinical service does not offer sufficient clinical variety, you are encouraged to spend time in other clinical areas, ensuring that both consultants are aware and approve of your 'visit'.

Assessment for the psychiatry rotation is based on:

- Clinical supervisor report: Your consultant's assessment of your ward/unit performance which includes a review of your Clinical Experience Checklist. Clinical experience checklist: This is a record of your activities while on attachment. It must be discussed with your consultant at the mid- point of your rotation and again at the end. The completed checklist contributes to your supervisor's report.
- Case history: A detailed study of one patient. Instructions are given in "Writing a Psychiatric Case History" in this handbook. The case history should not exceed 3000 words (excluding references and reflection). Anything longer will be subjected to a 10% penalty. The word limit forces you to be succinct: there is an enormous amount of information in a psychiatric case history, yet we must organise this into something that is useful and coherent. If you do not upload the case history via Turnitin by the deadline, there will likewise be an automatic 10% penalty.
- Critically Appraised Topic and presentation: Your CAT should follow the format provided by the School of Population Health at the EPIQ website. CATs may address aetiology, prognosis, diagnosis or treatment in presentations to your local audience. CAT marking sheets go to your local administrator. Ensure your CAT is scheduled well in advance of your presentation.
- Mini-CEX: At least two mini-Clinical Evaluation Exercises: one (or more) formative, one summative during Week 6 on which you are graded. Formative Mini-CEXs need to occur during the run, and if the first mini-CEX does not go well you should organise another one (or more) so that you can make sure you pass your final summative test. Suitable exemplar activities include taking a presenting history, taking a focused history for a particular symptom cluster, performing a brief neurocognitive assessment, performing a drug and alcohol history/assessment, performing a risk assessment (having observed someone take the full history), assessing medication side- effects. Other clinical skills may also be assessed

Grading for the course

The following table gives an indication of the requirements needed to achieve a provisional grade of distinction or pass for this attachment. It also indicates how a borderline performance or fail may be awarded.

To get	You require
Distinction	Distinction in the Clinical Supervisor Report <i>AND</i> Distinction in the Case History <i>AND</i> Distinction in the CAT or Mini-CEX
Pass	Minimum of Pass in the Clinical Supervisor Report <i>AND</i> Mini-CEX <i>AND</i> Borderline or Pass in the Case History or Borderline or Pass in the CAT
Borderline performance	Borderline Performance in the Clinical Supervisor Report or Mini-CEX or Fail in the Case History or Fail in the CAT or Borderline in the Case History <i>AND</i> CAT
Fail	Fail in the Clinical Supervisor Report or Mini-CEX or Fail in the Case History <i>AND</i> CAT

Recommended resources and readings



TALIS Reading List

To access the Year 5 Psychiatry TALIS reading list, either:

- Scan the QR code to the left using your smartphone

OR

- enter the URL below into your browser

www.fmhs.auckland.ac.nz/y5psych-readinglist

Online textbooks, handbooks and resources (9 items)

MyPsychiatry - Coursebuilder, University of Auckland, MBChB portal

(Webpage) | Essential resources

Oxford handbook of psychiatry - David Semple, Roger Smyth, 2013 (Book) | Textbook

Kaplan & Sadock's comprehensive textbook of psychiatry (electronic resource) - Benjamin J. Sadock, Virginia A. Sadock, Pedro Ruiz, Harold I. Kaplan, c2009 (Unknown) | Textbook

Managing children with psychiatric problems - M. Elena Garralda, Caroline Hyde, NetLibrary, Inc, 2003 (Book) | Textbook

Introductory Textbook of Psychiatry, Sixth Edition - Donald W. Black, Nancy C. Andreasen, 2014 (Book) | Textbook

100 cases in psychiatry - Barry Wright, Subodh Dave, Nisha Dogra, 2017 (Book) | Textbook

The Maudsley prescribing guidelines in psychiatry - David Taylor, Thomas E. Barnes, Allan Young, ProQuest (Firm), 2018 (Book) | Textbook

Psychiatric interviewing and assessment - Rob Poole, Robert Higgo, 2017 (Book) | Textbook

Clinical interviewing - John Sommers-Flanagan, Rita Sommers-Flanagan, c2012 (Book) | Further resources

Classification systems (3 items)

Diagnostic and statistical manual of mental disorders: DSM-5 - American Psychiatric Association, American Psychiatric Association. DSM-5 Task Force, c2013 (Book) | Essential resources

Diagnostic and statistical manual of mental disorders: DSM-5 - American Psychiatric Association, American Psychiatric Association. DSM-5 Task Force, c2013 (Book) | Essential resources

The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines - World Health Organization, 1992 (Book) | Essential resources

Printed textbooks (5 items)

Foundations of Clinical Psychiatry - Sidney Bloch, Stephen A. Green, Aleksandar Janca, Philip B. Mitchell, Michael Robertson, 2017 (Book) | Textbook

Kaplan & Sadock's synopsis of psychiatry: behavioral sciences/clinical psychiatry - Benjamin J. Sadock, Virginia A. Sadock, Pedro Ruiz, 2015 (Book) | Textbook | Print version available in library

New Oxford textbook of psychiatry - Michael G. Gelder, 2009 (Book) | Textbook

Foundations of clinical psychiatry - Sidney Bloch, Bruce Singh, 2007 (Book) | Textbook

Stahl's essential psychopharmacology: the prescriber's guide - Stephen M. Stahl, Meghan M. Grady, 2011 (Book) | Textbook

Handbooks (1 item)

Oxford handbook of psychiatry - David Semple, Roger Smyth, 2013 (Book) | Textbook

Writing a psychiatric case history

The clinical task and clinical logic

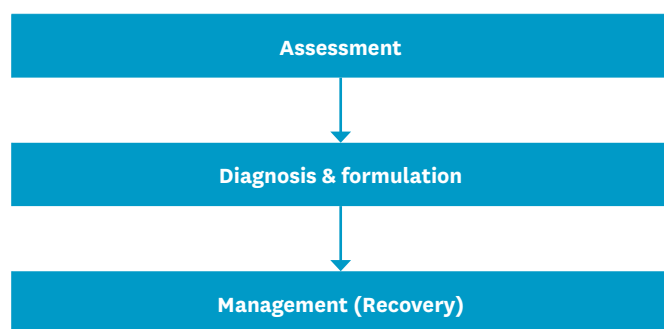
Taking a psychiatric history is unique. When you see a patient, the important aspects of the clinical task are to gather information, perform a mental state examination, develop a list of differential diagnoses and a formulation as to why the person is presenting at this point in their life. Also, it is necessary to develop a management plan.

The development of a comprehensive management plan requires the clinician (in this case student) to gather information (the assessment), to bring it together in the (provisional) diagnosis and formulation, which in turn will determine the development of the management plan. That management plan can be driven, for example, by the need for more or better information, or by specific therapeutic interventions or by both.

You will need to develop a rapport with patients so they will feel comfortable revealing important information. Listening to the patient in a way that conveys care and empathy is an important skill. You can practise your interview technique, summarising and using a mixture of open and closed questions. The process of gaining information is flexible.

Given the same assessment information, different clinicians might be expected to make the same diagnosis and formulation. Such perfection is in practice difficult as the information gathered is rarely identical and the process of selecting the content of the formulation is not perfectly objective. But in all cases, the link from assessment information to diagnosis and formulation should be logical and evident.

The full process of the clinical logic of the clinician/patient interaction is displayed diagrammatically below. The link between the assessment and the management plan is provided by the diagnosis and formulation.



The diagnosis and formulation should form the basis of a personalised management plan, and every part of the plan should be consistent with these.

One way of deciding which assessment information goes into the formulation can then be to go through all the assessment information underlining or otherwise extracting everything which will make a difference to the proposed management plan. That material forms the content of the formulation. This ensures that the formulation content is driven above all by the needs of the management plan, rather than being conceptualised simply as a summary of the assessment.

References:

Mellsop G W, Banzato CM (2006) A concise conceptualisation of formulation. *Academic Psychiatry*, 30:424-5

Selzer R and Ellen S (2014) Formulation for beginners. *Australasian Psychiatry*, 22: 397-401

Alyami, H., Sundram, F., Hill, A. G., Alyami, M., & Cheung, G. (2015). Visualizing psychiatric formulation. *Australasian Psychiatry*, 23(5), 575-580.

Case history general instructions

Please follow the structure found here:

- Include your name/student ID number and number each page of your case history submission.
- Make sure you submit the right draft of your case history.
- Discuss your case history with your consultant or registrar before submitting it.
- The case history should be a maximum of 3000 words (not including cover sheet, reflection and references); case histories exceeding this limit will attract a 10% penalty.
- A 10% penalty will also be applied to case histories submitted after the deadline of 9 p.m. on the last day of the attachment.

If you have problems with written English, we expect you to seek assistance for your case history. Ask assistance from the Student Learning Centre, friends or classmates. Microsoft Word has a spell/ grammar check so please use it. Poor written English can affect your mark.

Medical records or clinic files cannot be taken home. Patients' names, details or other identifying data should not appear in your report. Use pseudonyms or initials.

Do not "cut and paste" from medical records onto your case histories. It is much better to paraphrase information from medical records rather than copying it verbatim.

History

Introductory statement

This should be a sentence to orientate the readers to the case and to provide focus for discussion. It proves to the examiners that you are not just presenting facts elicited but that you have the skill to synthesise and make sense of a psychiatric presentation. It should describe what the main clinical issues are in the case – for example "this case is about the management of acute psychotic symptoms" or "this case illustrates the problems in preventing relapse of schizophrenia."

Other examples of introductory statements include: "this case illustrates the complexity of diagnosis in a person with a first presentation of depressive symptoms", "this case illustrates the clinical and ethical dilemmas of managing a woman with on-going suicidality" and "this case illustrates the importance of a comprehensive psychosocial rehabilitation assessment and strong treatment alliance in a man with a twenty year history of schizophrenia." These statements should be based on what you believe to be the crux of the issue. If safety concerns are present it is important to highlight these, for example: "this case illustrates the importance of managing suicide risk in an elderly man with an agitated depression."

Demographic information

Again one or two sentences –

This enables the reader to form a picture of the person. Include as much information as possible: age, gender, ethnicity, marital status, living circumstances, occupation (or how they derive income if unemployed) and mental health act status.

Presenting complaint

This is a brief description of the reason and context that you are seeing the person in for example “Mr Smith was referred to the liaison psychiatry service yesterday by the inpatient cardiology team who were concerned about his bizarre behaviour”

History of presenting complaint

Aim to convey a sense of the person's narrative of what they are presenting with and why now. Provide details of the relevant history, including current stressors and supports. Establish a timeline of important events by asking: “What were the main symptoms and behaviours?”

Qualify these:

Onset: When did they start (onset)?

Duration: how long?

(precipitating or mitigating factors: In what context did they start, get worse or get better)

Severity: how severe?

Impact: How have their symptoms affected their ability to carry out activities of daily living, roles as a family member, or job performance. How long have they been unemployed and why? How many days of work have they missed?

Functional inquiry: What other important features are associated with the presenting complaint?

Neuro-vegetative symptoms: sleep (pattern and quality), appetite, energy, libido, concentration, interest in and enjoyment of activities. Remember also to include important negatives that are relevant to the main issue. For example if the issue is around diagnostic uncertainty in someone who is psychotic, include the absence of thought disorder as this is important in deciding whether it may be due to schizophrenia.

Systems review

It is important to screen for co-morbid conditions and potential differential diagnoses. Remember that people may not always present this information without being asked. The range of conditions to be reviewed includes mood disorders, anxiety disorders, eating disorders, psychotic disorders, substance use disorders, dementia and cognitive disorders, and PTSD. Brief questioning can be used to explore each of these areas, supplemented by more detailed “drilling down” for diagnostic symptoms if positive answers are obtained. Document both relevant positive and negative findings.

Past psychiatric history

Pertinent events can be added to your timeline or chronology. These include:

1. Previous hospital admissions
2. Contacts with specialist mental health services
3. Episodes of care under mental health legislation
4. Past treatments, such as medication and psychological interventions. Document duration of treatments, whether these were helpful, and any adverse effects
5. Any past history of self-harm, violence or other risks towards others

Medical history

Use common sense and provide details for the most relevant medical history, don't write in detail on an appendectomy that is likely to be of no relevance. However, a diagnosis of diabetes in a man with schizophrenia is relevant given that 2nd generation antipsychotics in particular can significantly worsen glycaemic control and would require detailed discussion. Key points are physical illnesses and their treatment either presenting with psychological symptoms or increasing risk for an existing mental illness for example post-CVA depression or the impact of a chronic illness on an individual's personality development and mental well-being. This is often of major importance in the assessment of a young person with a chronic or severe physical illness. Clearly, a psychogeriatric or consult liaison case requires detailed consideration of the underlying medical history.

Current medications

List all current medications (both psychiatric and non-psychiatric including over-the-counter medications and health supplements) and include indications, dosages and timings. Use generic names rather than trade names – this is applicable to any medication mentioned here and also throughout the rest of the case history.

Family history

This section covers not just the family composition but also psychiatric/ medical diagnoses and treatment. A family genogram may be useful and also where the individual fits in the family birth order. Query about family suicides, substance abuse and other psychiatric disorders. For example, alcoholic parents are relevant for a risk of alcoholism in children but also vulnerability to personality or mood problems in children because of attachment experiences. Explore psychiatric disorder and response to treatment (if known), not only in the immediate but also extended family. This section does not only relate to genetic risk in the formulation but also the meaning of the illness to the individual.

Examples are:

“Mike's father died at age 72 years with a CVA but had a history of recurrent untreated depressive disorder throughout his life. His father previously worked as a mechanic and retired at 65.”

“Thomas is the oldest in a sibship of five and is closest to both his mother and younger sister Joan. He has a cousin with epilepsy and depression. His maternal aunt completed suicide when she was 32, 6 weeks after giving birth to her first child. He describes a chaotic and traumatic family life where he often witnessed his father assaulting his mother. Frequently, Thomas and his brothers would be taken from their home by different extended family members.”

It will be useful to describe the background of the family members e.g. occupation of parents, how the individual got along with them and other relevant information. It will be useful to describe siblings and their backgrounds briefly.

Personal history

Personal history to encompass: Developmental (including perinatal period and early development, education and work), Psychosexual and relationships, Substance use and Forensic histories.

1. Developmental history

Key areas need to be covered but again select information that is relevant to the overall presentation. Focus on the perinatal period and early development, education and work domains.

*****PLEASE BE VERY SENSITIVE ASKING THESE QUESTIONS***.**

This should cover antenatal, perinatal and birth history. Further, explore what was their childhood like, schooling and friendships. For example, “John had been to ten different schools by the age of fourteen and had difficulty forming friendships and learning to read or write. He frequently got into trouble with the teachers and was expelled at fourteen for assaulting a teacher.” This type of history is relevant to management as it predicts how people relate to others as adults including care givers.

History of abuse or trauma (emotional/sexual/physical) should be included. This also includes bullying. Patient's perspective on how it has affected him/her can be helpful.

*****PLEASE DO NOT ASK QUESTIONS ABOUT SEXUAL ABUSE WITHOUT DISCUSSING IT FIRST WITH YOUR CONSULTANT*****

You also need to give an occupational/employment history. For example: “Ann has worked for ten years as a bank teller after she completed her university degree in basic accounting.”

The relevance to management here is that one of the main impacts of an illness is on work, and maintaining/returning to work is often an important management goal.

2. Psychosexual and relationship history

It is valuable to provide details on a person's relationships with his or her parents; and significant intimate relationships. This gives clues to how a person learns to deal with conflict, loss and emotions. The aim is to establish the quality of relationships and patterns of difficulty in maintaining them. Recurring difficulty may indicate issues with self-esteem, coping style and personality.

In this section, it would be useful to provide details on menarche, first sexual encounter (where relevant) or first serious relationship. The aim is to establish the relationship frequency and quality and whether there may be difficulties in maintaining a relationship or other evidence of interpersonal dysfunction.

For example, "Ann married her first boyfriend at the age of nineteen but describes the marriage as loveless. She finds she has little in common with her husband and has never enjoyed sex as she finds it "dirty". Her husband is 10 years older and is described as "controlling". They have no children and Ann feels vulnerable in this relationship and wished she had seen other men before settling down."

3. Substance history

Document the quantity and frequency of substance use and the function of use. For example, alcohol has a predictable effect in making a person feel relaxed, sociable and help him or her forget about or avoid problems. Distinguish between use, problematic use, and physical or psychological dependence. Document contact with the community alcohol and drug services and other providers of therapeutic interventions, for example medical detoxification or residential rehabilitation. If substance abuse is a major part of the history, include this in the history of presenting complaint. For example "Jean drinks two bottles of wine a night. She has had at least five episodes of blackouts in the last year and two driving under the influence charges.

In the last week she has started to have tremulous hands in the morning which disappear when she takes 5mg of diazepam prescribed by her GP for anxiety. Last year, she went to one AA meeting after an ultimatum from her partner but has had no help since." Note a common omission by students is that after detailing a significant history of abuse / dependence they forget to include it in their diagnosis, formulation and management plan.

4. Forensic history

Include contacts with the police and criminal justice system. Document information about convictions and sentencing such as periods of incarceration. If the history of offending is extensive, you may wish to summarise the nature and pattern of the offending in relation to a mental disorder, such as a series of increasingly violent offences over a year associated with the onset of untreated psychosis.

Forensic cases can be complex. Forensic patients may be found unfit to stand trial or not guilty by reason of insanity. In this case, they may be made special patients. If you have a forensic patient, focus on the clinical aspects. You can mention if the patient is pending trial but you do not need to elaborate with great detail about the legal aspects of the case.

If there is no forensic history, state this as a negative e.g. There is no forensic history.

Premorbid personality

Although seemingly difficult, it is possible to assess a person's premorbid personality by exploring a few key areas. The first of these is by asking the patient (and/or family) what kind of person the patient was prior to the onset of illness, or how their family or friends would have described them. Of interest, psychologists have identified 5 personality factors including openness to experience, conscientiousness, extraversion (tendency to be sociable, active and willingness to take risks), agreeableness (ability to relate – trust, tenderness) and neuroticism (emotional instability, tendency to anxiety). Asking questions about these may help build up a picture of the person. Secondly, asking about how the patient has coped with difficult situations in the past will help build a picture of how they may be coping with their current situation and when facing future events and treatment.

It is generally inappropriate to label someone with a personality "disorder" unless you are very clearly able to defend the case, based upon both cross-sectional and longitudinal information. It is better to say "Sam has features/traits of an obsessional personality. He describes a need for orderliness, perfection and control over a number of aspects of his life".

Hobbies/interests, prevailing attitudes, dealing with stress, coping strategies and religion are good things to present here too.

Current Social Circumstances

Students are usually good at this given their experience with clerking medical and surgical patients. Areas to cover include - who is the current source of support for this patient? Any housemates? Close relatives or friends? Children? Current source of income? Financial situation? Is the patient receiving any benefits? What is their housing situation?

Mental state examination (MSE)

This is the art and science of psychiatry. It must be organised, detailed and consistent with what has been presented. Use the phenomenological terms and be sure you can justify and define them. Do not leave out any sections - you cannot say "cognition was not assessed" unless you have an exceptionally good reason such as the patient walked out of the room. See Appendix 2 and be sure to include:

B - Behaviour/appearance

O - Orientation and cognitive functioning

A - Affect and Mood

T - Talk/Speech, Thought Form and Thought Content

P - Perceptions

I - Insight and Judgment

S - Safety risks to self/others; Self-care

Appearance, behaviour, eye contact and rapport

Paint a picture of the person in front of you – it is good psychiatry and makes it interesting to listen to e.g. "Paul was dressed in unevenly buttoned hospital attire with a ripped denim jacket on top. During the interview he remained curled in a corner of the couch and avoided eye contact. Rapport was difficult to establish as he seemed frightened both of being in hospital and the experiences he was going through." Comment on the quality of the rapport. Describe the process of engagement and communication. Rapport may be influenced by your approach to the assessment but also by context, communication and the severity of the patient's symptoms at the time.

Document your observations about the person's behaviour. You can also document your reactions during the interview (e.g. discomfort in engaging with an angry patient or feeling overwhelmed by a person who is anxious or tearful).

****USE PROFESSIONAL LANGUAGE. DO NOT MAKE JUDGEMENTAL OR DEROGATORY REMARKS ABOUT THEIR APPEARANCE****

Orientation/Cognition

Present results of a cognitive screening tool such as the mini-ACE (see Appendix 5) or the Rowland Universal Dementia Assessment Scale (RUDAS). In addition Frontal lobe bedside testing can be added. State whether there were any cognitive abnormalities as this is always relevant and state which tests were abnormal. For example: "...Mrs Jones scored 24/30 on the mini-ACE. She made two errors on testing of attention and concentration and scored two out of three on short-term memory testing at five minutes. On frontal lobe testing she displayed several deficits. She perseverated on copying alternate patterns of W's and M's. She perseverated on alternate tapping testing and had a reduced verbal fluency, only naming 8 words beginning with 'A' in one minute with two repetitions..." If a cognitive assessment is not possible you can still comment on whether the person was able to attend to the whole interview, was orientated to time, place and person, could follow complex instructions, was able to recall recent events and past events. Had good/poor short term memory.

Speech

Comment on rate, rhythm, volume and intonation. Use descriptive terms rather than stating these were normal.

Thought form

Mention whether the thought form was logical and goal-directed or irrational and whether there is evidence of loose associations or flight of ideas. Giving examples helps.

Thought content

Document delusions, ruminations/obsessions or overvalued ideas if present. Describe what the person is actually saying to you e.g. "Tom spoke in a self-deprecatory manner outlining his many failures over many years." Use accurate terminology regarding delusions – especially highlight threat/control/passivity as very relevant for dangerousness. SUICIDE/HOMICIDE (safety risks) can either be included here or as a separate category at the end.

Perception

Illusions are misperceptions of real objects and hallucinations are perceptions in the absence of external stimuli. These can occur in any of the five sensory modalities (auditory, visual, tactile, olfactory, gustatory). Visual and olfactory hallucinations are more commonly associated with organic pathology. Auditory hallucinations are more suggestive of functional psychiatric disorders, such as schizophrenia. Command auditory hallucinations are associated with an increased risk of harm to oneself and to others, so should always be explored and documented if present.

Mood and Affect

Mood is a person's overall state of feeling and should be described from both subjective (how the person says they feel e.g. "Mark says he is feeling low" or "Mark rates his mood as 4/10 today") and objective perspectives (e.g. "the patient appeared apathetic, euthymic, dysphoric, despondent, depressed, elevated, etc.). Affect describes the more immediate aspects of mood observed during an interview (if mood is the climate, affect is the weather) and should be described in terms of range (e.g. expansive vs. restricted), reactivity (e.g. blunted, excessive), lability and congruence (matches what is being said or is different e.g. a psychotic person smiling and seeming happy while describing how they are being persecuted by demons).

Affect is the person's emotional expression that you observed on cross-section during the interview. The parameters of affect are:

- Range that you observed e.g. affect was restricted to dysphoric and anxious range,
- Intensity, the lack of or extreme emotional expression e.g. blunted affect, common in people with negative symptoms of schizophrenia or heightened with mania
- Reactivity, the affect change in response to your questions e.g. if a patient fails to respond to evocative stimuli, affect can be described as nonreactive
- Congruence, the match in emotion with situation or topic of discussion e.g. the patient blandly described frightening delusions of persecution. The term appropriate can also be used.
- Mobility, the rate of change of affect e.g. labile affect with the patient fluctuating rapidly between crying, laughing angry and calm. Aim to describe as many of the parameters of affect as possible.

Insight

This has several parts:

1. Does the person think that something is wrong
2. Do they see symptoms as illness?
3. Do they see symptoms as part of mental illness?
4. What is their attitude to help seeking/treatment?
5. Do they understand the impact of their illness?

Try and explain the person's level of insight by relating it to the appropriate

part of the MSE (e.g. is it the person's mood, psychosis or cognition that makes insight less than full?). It is inadequate to say "insight is impaired" "insight is partial" without adequate exploration of the components of insight. In people with personality disorders, the concept of psychological insight is important, e.g., do they correctly recognise the impact of their behaviour on others?

Judgement

How does the mental state you have presented impact on decision-making regarding their actions. Clearly, key ones include risk of suicide, risk to others and ability to care for oneself. Again don't make global statements without discussion – it is not adequate to say "judgement is impaired" without saying why and how.

Safety and risks

This is an important area to explore. Document potential risks such as risks to self or others; risk from others; and risk of self-neglect.

Some elements of a suicide risk assessment may be covered under the section on thought content. Specific areas to explore include strengths, long term risk factors, impulsivity, past suicidal behaviour, recent and present ideas of suicide, stressors, symptoms and engagement with health services. You can comment on available resources which support the person's safety and treatment and foreseeable changes that can quickly increase the person's risk. You can state the person's risk (relative to baseline) and factors that are likely to increase the person's risk. This is also known as a risk formulation.

Physical examination

Keep this brief and tailored – in the presence of significant physical illness, more detail may be needed e.g. detailing physical findings of Parkinson's disease. In eating disorders, mention weight + height for BMI and look for physical features of anorexia or bulimia. For example: "on physical examination, Jane had a BMI of 16, her skin was dry and showed lanugo hair. Her teeth were chipped with dark staining. On cardiovascular examination, she was bradycardic with a regular pulse of 48/minute. Her BP was 110/60 and her heart sounds were heard with no murmurs. Her temperature was 36.5°C. No further abnormalities were detected on a brief examination." In someone with a primary substance abuse diagnosis, look for stigmata of alcoholism or needle marks. In someone on long-term antipsychotics, include inspection of the abdomen, a brief neurological exam to look for features of Parkinsonism, and do an AIMS (abnormal involuntary movement scale). In someone on lithium, look for tremor/hypothyroidism. If there are grossly abnormal physical findings, you need to talk about how that was assessed and managed in the appropriate parts of the Case History.

Formulation

Formulation is one of the crafts of psychiatry. A formulation is more than a summary. It provides an opportunity for you to draw together the threads of the assessment and define how you understand this person's presentation.

Key questions for the formulation are: Why is this person in this predicament? Why is she presenting with these symptoms? Why now? There are various ways to formulate a case and you can use the bio-psycho-social-cultural-spiritual model in which the following areas ("the 5 Ps") are presented using a combination of biological, psychological, social, cultural and spiritual information obtained during the interview and by gathering collateral information:

- An explanation of predisposing life events or vulnerabilities (e.g. genetic predisposition to developing a mood disorder, poor early attachment).
- A description of precipitating stressors or life events (e.g. relationship stress, substance abuse, non-compliance with medication, developmental stage).
- A description of perpetuating or maintaining factors which explain why things haven't gotten better or completely resolved (e.g. lack of insight,

stigma regarding mental illness, family pressure, use of substances).

- A description of strengths and protective factors that explain why things haven't become worse than they are (e.g. intelligence, effective coping strategies, keenness to seek help, family/ whānau and cultural support)).
- An estimate of prognosis with or without appropriate care or treatment (e.g. chronic course, risk of suicide, likely issues with treatment based upon presentation and history).

Diagnosis

This is a summary of the person's symptoms using an established classification system such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the International Classification of Disorders (ICD-10). Present your primary or most likely diagnosis as well as possible differential diagnoses. Justify diagnoses on the basis of DSM or ICD criteria and why you ruled in or out diagnoses. With the classification system you've used, make sure to include current as well as historical diagnoses. The multi-axial classification system of DSM-IV has distinct advantages and can be adapted for use with DSM-5 or ICD-10 (the multi-axial system of DSM-IV was unfortunately, and unnecessarily, dropped from DSM-5).

Management Plan

The management plan includes both investigations and treatments. It should be a personalised plan taking the aspects discussed in the formulation and developing strategies to manage these. It should include what you would consider doing in the context of having unlimited resources, not necessarily what actually occurred with the management of the patient.

1. Safety

What are the current safety concerns? Priority lies with immediate risk to self from suicidality or diminished self-care, and risk to others. Be aware of risk factors e.g. age, gender, substance use and significant past events and personality style. An accurate and thorough mental state examination will identify features which specifically increase risk e.g. command hallucinations, delusions of threat/control, an irritable and elevated mood or suicidal ideation. Long-term risk relates to on-going factors either in the individual's mental state or environment.

Psychiatry has moved away from predicting dangerousness to managing risk. Strategies for managing risk include engagement with the individual, frequency of contact, and education around early warning signs for illness relapse. Increase in nursing and medical supervision, respite admissions and or acute in-patient hospitalisations are options in managing unwell and unsafe patients. On some occasions, the Mental Health Act may be required to ensure appropriate medication use or inpatient care at times of acute illness or situational crisis. An active plan to address substance use issues may be part of managing safety as may attention to environmental stress such as housing stability.

2. Clarifying diagnosis and differential diagnosis

Is it clear what the individual's diagnosis is? It is surprising how many patients are treated within the mental health system whose diagnosis is not clear. Clarifying the differential diagnosis includes obtaining a thorough longitudinal history from the individual, reviewing old psychiatric and medical notes, obtaining collateral history from family members (by way of a family meeting) and GPs. Where possible identify and acknowledge the gaps in your case history and outline what further information you may require.

3. Cultural issues

The individual and family's cultural identification must be established on first contact. This is so the family and individual can have access to culturally appropriate support and the staff can receive advice on how to work with the patient and appreciate their world view. It is essential to utilise the interpreting service when the patient requests this or when there is serious doubt about competency in spoken English.

4. Biological management

a) Pertinent diagnostic tests and examinations

Consideration of the physical health of the individual is essential. This is in part because physical conditions may present with an altered mental state e.g. delirium with sepsis, or mood disorder with endocrinopathy. Another important reason is because of the many psychiatric side-effects of medicines taken for physical conditions.

It is often important to establish baseline physical investigations prior to prescribing many medications e.g. renal and thyroid function prior to commencing lithium, electrolytes in the elderly before prescribing SSRIs, or an ECG prior to clozapine initiation.

Additionally, there are drug plasma levels that can be tested, if indicated, including lithium, valproate and clozapine. In certain populations, a comprehensive physical examination and investigations are particularly important e.g. potentially life-threatening conditions such as anorexia nervosa. It is important to remember that patients with schizophrenia have poorer general physical health than the general population and often do not access GPs.

A physical examination on someone prescribed antipsychotic medication must include an examination for extrapyramidal side-effects.

Neuroimaging should be considered for first episode psychosis as well as new onset cognitive disorder. ECG should be considered prior to commencing psychotropics and, if indicated during treatment to monitor for rhythm disturbances, notably including prolonged QTc. Further, a urine drug screen can be helpful when considering the possible (and common) contribution of substance abuse to mental disorder.

b) Medication

The other major component of biological management is medication. What does the evidence tell us about which medications are effective for someone with this condition? Clearly the attitude of the patient and their family to medication is important. A discussion of the advantages and disadvantages of medication and possible side-effects is obligatory for good management. It is also important to discuss the dosing regimen, the expected time for effect, the need for any special monitoring and practical issues such as what to do if a dose is missed. There should also be a statement on how often the person will be reviewed. Written information sheets in the appropriate language are important. Directing patients to websites which detail medication side effects can be helpful, including www.medsafe.govt.nz

ECT can also be considered, particularly for severe or treatment-resistant depression.

5. Psychological management

Psychoeducation (discussing what the individual's condition is and potential treatment strategies) and exploring the patient's coping style and aggravating stressors are components of general psychological management. Additionally, specific psychological therapies may be indicated such as cognitive behavioural therapy for depression or anxiety disorders. Psychological management may include special assessments such as neuropsychological testing. As with all management, psychological strategies should be a planned intervention with specific goals and outcomes to be evaluated.

Other psychological interventions to consider include sleep hygiene, relaxation techniques and breathing exercises for anxiety, behavioural activation, online cognitive-behavioural therapy for depression/anxiety (e.g. SPARX, Beating the Blues) and potentially motivational interview techniques. For certain personality disorders e.g. borderline, dialectical behavioural therapy should be considered.

6. Social and family issues

A major criticism of mental health services has been the lack of communication with family members. Family members are not only a valuable source of information but are often a major support in the individual's recovery process. Families may experience their own stress

from seeing a member unwell and community organisations such as “Supporting Families” can be invaluable. Family support groups from the CMHC’s and inpatient units are also useful resources. Specific interventions involving the family such as Integrated Mental Health Care or Family therapy may be indicated. The individual’s family or major social support person should be involved in developing a wellness plan with early warning signs and contact numbers.

Social issues often relate to housing, money, education and employment. There is clear evidence that, for people with on-going mental illness, the quality of housing influences functional outcomes including maintenance of relationships, employment, and survival outside hospital. Hopefully, as a service we can move past the language of “placement” to working together with the individual to find a stable home. Assessment of living skills may alert the team to specific needs for the individual for example, budgeting or cooking. Management of employment issues may range from providing a letter to employers supporting a gradual return to the workplace to a referral to specialist agencies.

7. Rehabilitation Management and the Recovery Model

This is of more relevance to patients with the more severe and enduring mental disorders. Rehabilitation is not concentrating solely on symptoms but rather assesses the impact of the illness on the individual’s ability to function within and as part of the community. Establishing goals with the individual and their family and looking at the steps needed to achieve these are important. A rehabilitation plan identifies areas for skill retrieval, skill development and community integration.

Students should also be aware of the ‘recovery model’ which guides much of NZ’s mental health service policy and expenditure:

<https://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-work-ministry>

Reflection and references

Reflection

Reflective practice is a lifelong skill. This is an opportunity for you to consider the case in the wider context of psychiatry, what you have learned and its impact on you as a clinician. You could include what you have observed about working in a team, how you felt about your placement or more general thoughts about the practice of psychiatry.

References

Provide specific references, for example those used to support your preferred diagnosis and for justifying your choice of management strategies, e.g. clozapine for treatment-resistant schizophrenia or ECT for severe depression. References are also useful to indicate that you have critically appraised the validity of contested diagnoses, or the (at times) doubtful evidence for existing treatments.



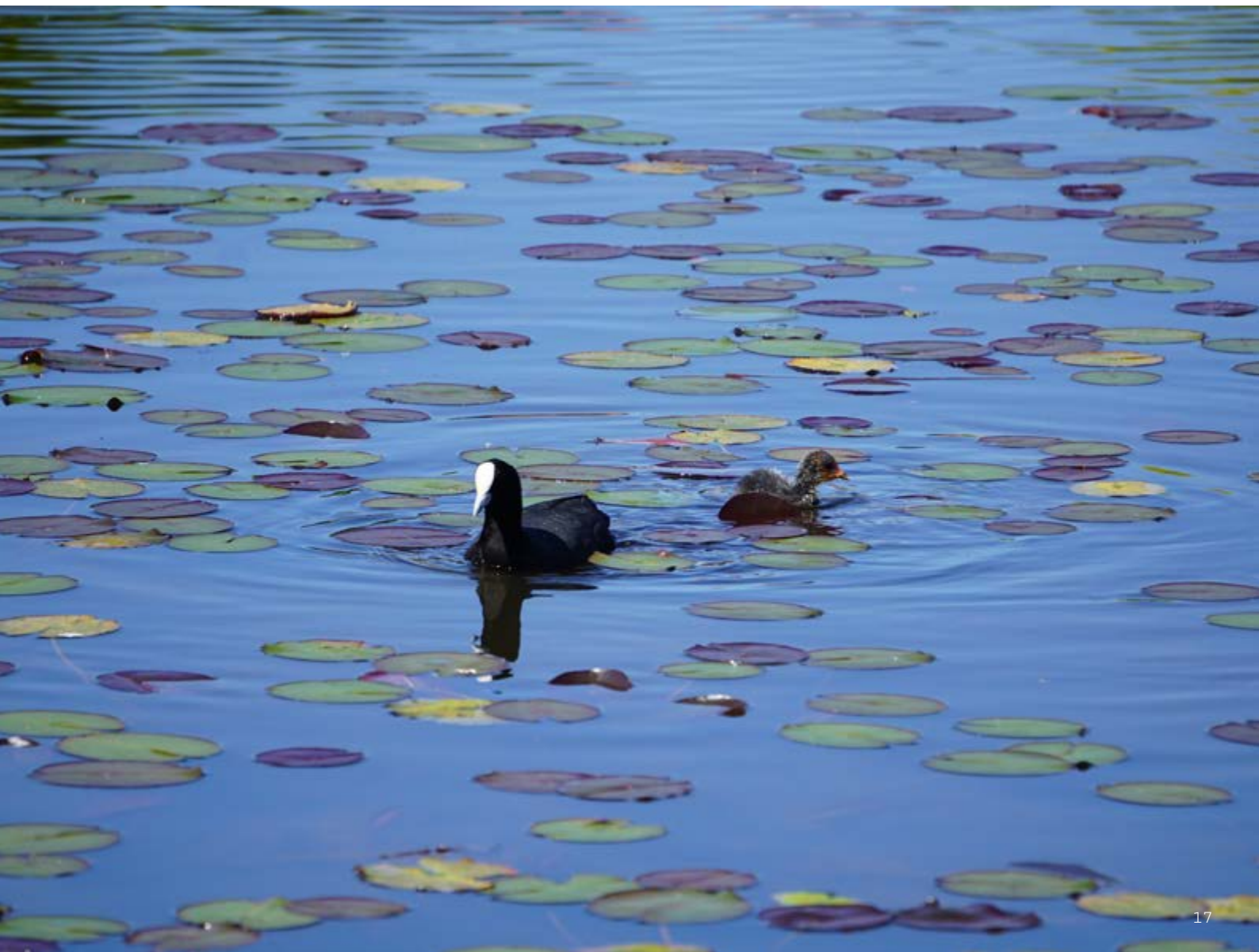
Child and adolescent psychiatry

As child psychiatric disorders are common (around 17% prevalence), under-recognised and under-treated we would like to ensure that you leave your psychiatry experience with an understanding of how to assess mental health problems in children and adolescents within a family context, a knowledge of common child and adolescent psychiatric illnesses and how to manage them.

We have a limited time to achieve these aims and not all students can access child and adolescent clinical experience, although we hope this will change in the next few years. We have organised the teaching in child and adolescent psychiatry to optimise the resources we have available.

There are a number of components to the Child Psychiatry teaching.

1. Practical skills-based sessions on interviewing children and adolescents with mental health problems. Timing of these depend on your cohort site.
2. Formal Learning weeks for 4 hours (subject to change). This covers common conditions and their management: read the chapters about common childhood conditions in the recommended textbooks before you come.
3. Where possible, please arrange to spend at least one day in a Child and Adolescent Mental Health service in your cohort site. Your consultant or cohort tutor can advise on contacts with regards to this.
4. View the Mental Health Commission videos online via the Philson (see Recommended Resources and Readings) and also access the Child and Adolescent Psychiatry resources on MyPsychiatry.



Appendix 1

Summary of the main sections in the history

- Introductory statement
- Demographic information
- Presenting complaint
- History of presenting complaint
- Systems review
- Past psychiatric history
- Medical history
- Current medications/treatments
- Family history
- Personal history
 - Developmental history
 - Perinatal period
 - Early development
 - Schooling
 - Occupations
 - Psychosexual and relationship history
 - Substance abuse history
 - Forensic history
- Premorbid personality
- Current social circumstances

Appendix 2

Mental state exam summary

Appearance:

Age, gender, race/ethnic background, build, hairstyle and colour, apparent health level of hygiene, mode of dress, physical abnormalities.

Behaviour:

Eye contact, cooperativeness, motor activity, abnormal movements, expressive gestures.

Speech:

Articulation disturbance, rate (rapid, pressured, slow, retarded), volume (loud, quiet, whispered), quantity (poverty of speech, monotony, prolixity).

Mood/affect:

Mood (objective and subjective) e.g. elevated, depressed, labile, angry, euphoric; affect (objective) e.g. irritable, blunted, flattened, incongruent, anxious; range and intensity, stability, appropriateness and congruity.

Thought stream:

Amount or speed of thought: Poverty of thought, pressure of thought; slow or hesitant thinking.

Thought content:

Delusions of persecution; reference; delusions of control/influence/passivity; thought insertion; thought withdrawal; thought broadcasting. Other delusions not necessarily associated with schizophrenia: religious, nihilistic, morbid jealousy/infidelity, grandiose, guilt and worthlessness, somatic/hypochondriacal. Other: phobia, obsessions/compulsions, overvalued ideas.

Thought form:

Amount of thought and its production: Poverty of ideas; flight of ideas; perseveration; loosening of associations. Continuity of ideas: Loosening of association/derailment, tangential, circumstantial, perseveration (repetition of same thoughts), thought blocking, concrete thinking, irrelevance. Disturbances in language: Neologisms, incoherence/word salad, clanging.

Perception:

Hallucinations: auditory; visual; olfactory; gustatory; tactile. Depersonalisation; derealisation and illusions.

Cognition:

Level of consciousness/alertness; memory; orientation (time, place, person); concentration; abstract idea.

Insight & judgement:

Capacity to organise and understand problem, symptoms or illness; knowledge of medication; amenable to and compliance with treatment; impaired judgement.

Risks:

to self or others, from others, from neglect

Appendix 3

Introduction to Psychiatric Interviewing

Important components of the interview:

1. Content (gathering information).
2. Process (how you connect with the patient during the interview through verbal and non-verbal communication).

Process of Psychiatric Interviewing

Tricks to help establish good rapport during a psychiatric interview:

1. Use of open-ended questions (spend at least 2-3 minutes at the start of an interview doing this).
2. Clarifying leads (picking up on clues given by patients and exploring these further).
3. Demeanour and posture (choosing appropriate distance, adjusting degree of lean, avoiding a focus on taking notes, and maintaining eye contact).
4. Framing of questions (avoid difficult direct questions when there is another way to extract the same information, normalizing the subject may help, and use terminology that patients can relate to, for example using 'have you had thoughts of ending your life' instead of 'are you suicidal').

Content of Psychiatric Interviewing

Useful information from the patient:

1. Demographics (age, sex, ethnic background, marital state, profession, supports in place).
2. Understanding the Presenting Complaint (why is the patient here or what complaints are others making).
3. History of Presenting Complaint (detailed version of the story, triggers, stressors, motivations, explanations, what exacerbates and what relieves, frequency of symptoms, etc.).
4. neuro-vegetative signs and symptoms (quality of sleep, energy, concentration, appetite, libido), interest in and enjoyment of pleasurable activities.
5. Past Psychiatric History (Previous diagnosis, medications, psychotherapy and hospitalizations).
6. Medical History (current medications, active or past medical and surgical conditions, allergies).
7. Developmental History (childhood experience, history of trauma and positive relationships).
8. Drug & Alcohol History (masquerades as many psychiatric conditions, important to consider before committing to another diagnosis).
9. Family History of Psychiatric Conditions (psychosis, mood disorders, drug & alcohol, intergenerational abuse, etc.).
10. Social History (Profession, hobbies, routines, stressors, relationships, aspirations, worries and family).
11. Mental State Examination.

Three types of interview questions

1. "Big net" questions (usually open-ended questions that explore broad symptom clusters, useful in first encounters to give the interviewer a good idea of the general type of illness present)
2. "Clarifying" questions (follow-up of clues dropped in response to "big net" questioning, helps further identify the type and extent of the psychiatric disorder)
3. "Checklist" questions, Important in Exams (Medical History, Past Psychiatric History, Developmental History and Drug & Alcohol)

Depression

Questions based around symptoms specific to depressive disorders:

1. General Mood (How's your mood been? Where's your average mood on a scale of 1 to 10? When things were well, what was your mood like?)
2. Neuro-vegetative signs and symptoms (how much these 5 are affected may give you some insight as to the severity of the disorder)
3. Anhedonia (What things do you usually enjoy doing? Are you still enjoying those things? Have you noticed changes in the way you enjoy things you previously enjoyed?)
4. Guilt and Self-blaming (Have you noticed you've been blaming yourself more than usual? Have you been more disappointed with yourself than usual?)
5. Worthlessness, Suicidality (Have things been so low that you just don't want to be around anymore? Do you sometimes feel that life is just too much and you would be better off dead? If yes you MUST pursue this, find out the extent of these thoughts and any plans for suicide)

Mania

6. Bipolar patients rarely present to health services when they are high, unless they are disruptive or severely manic. It is much more likely that you will see these patients during their depressed phases.
 - Quick way to screen for past mania when interviewing someone depressed is: Have you experienced the opposite of what you are feeling now? And during this time your energy was high, you needed less sleep than you normally do and you were doing things you usually would not do?
7. In a patient presenting in the manic phase, questions may be more straightforward. For example, how's your mood been lately? Have you noticed anything happening with the number of hours you sleep? (IMPORTANT) How are your energy levels? (Paradoxical increase in energy in relation to number of hours slept) Any changes in how fast you think, or how fast you talk? Any new interesting plans or projects? (Inflated ego, grandiosity)
8. Important questions surrounding risk for manic patients include: How's your driving been, going faster than usual? How is your financial situation? Have you been more interested in gambling lately? Any changes in terms of your sex drive? Have you tried anything you usually wouldn't or had sexual encounters with people you usually wouldn't? Have you had any arguments or fights recently?

Anxiety Disorder

1. Most patients go to the doctors with physical signs of anxiety rather than complaining of feeling anxious. In order to uncover a history of anxiety, it may be helpful to ask a screening question such as: are you the type of person to worry about things? What makes you tense or anxious? Compared to an average person, are you anxious? Are you a worrier?
2. **Physical signs:** When you are anxious, what kind of things do you experience?
3. **Panic disorder:** Out of the blue have you had the feeling like you are about to have a heart attack? Heart racing, tingling, difficulty breathing? How long do they last for? (panic disorder consists of discrete episodes lasting for up to 20 minutes) How many times have you had it in total? (classically, these occur a few times a month, not a one-off event) During these episodes, do you get tummy aches or feel sick? Faint or dizzy? Do you feel like you are separate from your body? [depersonalization] do you feel like your surroundings are not real? [derealisation] do you feel like you are going to die or going crazy? [catastrophizing]

4. **Social phobia:** do you get very self-conscious when you're on the spot? What's your worst fear when you're the centre of attention? Can you give examples of when this happened to you? What's your experience with speaking in front of a crowd? [most social-phobics will not be able to do this] how comfortable do you feel eating or drinking in public? Are you comfortable talking on the phone? [social-phobics fear what they say or how they say things are constantly being scrutinized by others]
5. **Generalized Anxiety Disorder:** What are your worries? What is it about that that worries you specifically? [often valid concerns like health/finance/relationships/ safety of loved ones, but the intensity is disproportionate] What other worries do you have? What's the worst case scenario? [these may be extreme!] With all these concerns have you noticed anything physical? Palpitations, sweating? Difficulty breathing, chest pain? Dizziness or light-headedness? Muscle tension, restlessness? Also ask about neuro-vegetative signs.
6. **Obsessive-compulsive Disorder:** Obsession=Unwanted pervasive thoughts, images or impulses (Some people often get very distressing thoughts in their minds that are not under their control, do you ever get anything like that?) Compulsions=behaviours that decrease their worry (With these persistent distressing thoughts, do you do things to lower your anxiety? For example, wash hands, check locks, perform rituals?)
7. **Post-traumatic Stress:** Have you experienced a traumatic event that triggered all these symptoms? [defining event, commonly life-threatening] Have you noticed changes in yourself after the trauma? Do you experience dreams or flashbacks going back to the trauma? [re-experiencing phenomenon] Have you noticed you're more uptight or on edge since the incident? [hyper-vigilance] Have you noticed you've been avoiding people or places you usually don't? [avoidant behaviours]

Suicidality

This section is already at the end of the 'screening for depression' section.

Psychosis

1. Questions aimed at exploring hallucinations: Have you noticed your mind is playing tricks on you? Hear things when nobody's there? [Auditory] See things that you know aren't real? [Visual] What do the voices say? Do they speak to you (2nd person) or about you (3rd person)? Do they tell you to do things? [Command] Are they nasty? [Derogatory] How many voices? Do you recognize them? Can you describe them to me? How loud are they? From 0 to 10, 10 being super loud, how would you rate them? How often do you hear them?
2. Questions aimed at exploring delusions: Have you had the experience that people are out to get you? [persecution] What about a feeling that people are watching or monitoring you? [paranoid] Do you experience this even when you do not use alcohol or drugs? [rule out drug abuse/substance-induced psychosis] Sometimes, people feel that there are subtle meanings or messages directed at them personally from adverts, internet or social media. Do you get them? [ideas or delusions of reference]

Alcohol & Substance Use

1. Alcohol abuse: describe quantity/frequency and specify number of units per week.
 - Specific questions to ask around abuse: C.A.G.E. = Cut down?; have you had thoughts of cutting down on drinking? Anger; have you been angry when people ask you or talk about your drinking? Guilt; have you felt guilty about the amount you're drinking or how your drinking? Eye-opener; has it reached a point where you have to drink in the morning to feel better?
2. Dependence: Targeting Tolerance; have you noticed you need more to achieve the same effects?
 - Targeting Withdrawal; do you feel shaky, sweaty, palpitations, nauseous when you stop drinking? Targeting Functional interference; have you had problems at work, at school, at home or with the police?
3. Substance Abuse screen; outside of alcohol do you use recreational or "party" drugs?

Somatoform Symptoms

Useful questions: What are the physical symptoms troubling you? [often patient has a list] What are the top 3 things? How has this affected your life? What kind of tests have you had? Who are the specialists that have been involved? [patients truly experience these symptoms, not pretending for ulterior motive] What's your interpretation of these normal specialist results? [shows their insight into condition] Are these symptoms related to your emotional state or stress levels?

Borderline Personality Disorder

1. Characterized by mood dysregulation with rapid swings; How's your mood? How stable has your mood been? Do you experience rapid shifts in your emotions? What are the triggers for these mood shifts? [often feelings of abandonment, not being cared for]
2. Poor impulse control with tendencies to be destructive towards others or to self; When you're in an emotional state, what kind of things do you do? How do you get relief? How do you relieve the tension? Do you become really angry towards others? Do you hurt yourself?
3. Triggered by relationship issues, perception of abandonment, or feelings of rejection; How's your relationship at the moment? Does it feel like a rollercoaster ride? What are the highlights? What about the low points? Overall, how many significant relationships have you had? How did your previous relationship end? Do you have worries about being alone?

Appendix 4

HEADSS assessment for adolescents (aka HEEADSSS)

Home

- Who lives with the young person? Where? Do they have their own room?
- What are relationships like at home? Siblings?
- Supervision? What are the rules like at home?
- What do parents and relatives do for a living?
- Parental substance use, separation, divorce?
- New people in home environment? Recent life events?
- Recent moves? Running away?
- Ever institutionalized? Incarcerated?
- Anything they would like to change at home?
- Cultural identity?
- Community support?

Education and employment

- School/grade performance - any recent changes? Any dramatic past changes?
- Favourite subjects - worst subjects? (include grades)
- How many hours of daily homework?
- Any years repeated/classes failed
- Suspension, termination, dropping out?
- Relations with teachers, employers - school, work attendance?
- Any current or past employment?
- Future education/employment plans?

Activities

- On own, with peers (what do you do for fun? where? when? who?)
- With family? best friend?
- Sports - regular exercise?
- Church attendance, clubs, projects?
- Online - how much weekly, websites/apps
- Hobbies - other activities?
- Reading for fun - what?
- TV - how much weekly, favourite shows?
- Favourite music?
- Does the young person have a car, use seat belts?
- Risk-taking?
- History of arrests, acting out, crimes?

Drugs

- Use by peers? Use by young person? (include tobacco, alcohol, caffeine, illicit substances)
- Use by family members? (include tobacco, alcohol, caffeine, illicit substances)
- Amounts, frequency, patterns of use/abuse, and vehicle use while intoxicated?
- Source - how paid for?
- Recent increases or decreases

Sexuality

- Orientation?
- Degree and types of sexual experience and acts? frequency?
- Number of partners?
- Masturbation? (normalize)
- History of pregnancy/abortion?
- Sexually transmitted diseases - knowledge and prevention? contraception?
- Comfort with sexual activity, enjoyment/pleasure obtained? History of sexual/physical abuse?

Suicide/Depression

- Sleep disorders (usually initial insomnia, also early/frequent waking or greatly increased sleep and complaints of increasing fatigue)
- Appetite/eating behaviour changes
- Feelings of 'boredom'
- Emotional outbursts and highly impulsive behaviour
- History of withdrawal/isolation
- Hopeless/helpless feelings
- Suicidal ideation (including significant current and past losses)
- History of past suicide attempts, depression, psychological counselling
- History of suicide attempts in family or peers
- History of recurrent serious "accidents"
- Psychosomatic symptomatology
- Subdued affect on interview, avoidance of eye contact
- Preoccupation with death (clothing, media, music, art)
- Bullying, possible reasons for this

Strengths

- How would you describe yourself? How would your best friend describe you?
- What are you best at?
- Does your family attend a place of worship? What do you think about that?
- Do you believe in something outside yourself?
- Who do you talk to when you feel upset about something/when you feel really happy about something?

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