YEAR 5 PSYCHIATRY

UNDERGRADUATE HANDBOOK

2016

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

MEDICAL AND HEALTH SCIENCES
SCHOOL OF MEDICINE

He aha te mea nui o te ao?

He tangata! He tangata!
He tangata!

What is the most important thing in the world?

It is people! It is people!
It is people!

Contents

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 health disorders will never be seen by a psychiatrist or mental health service, but will present to their GPs or hospital specialists, sometimes with somatic symptoms.

What are the different areas of psychiatry?

Modern psychiatry has divided into a number of sub-specialities: Child and Adolescent psychiatry concentrates on disorders in children and adolescents, Forensic psychiatry studies the interaction between psychiatry and the law, Psychogeriatrics examines the psychiatry of old age, Consultation-liaison psychiatry deals with the interaction between physical and mental disease in the broadest sense and includes psychosomatic medicine and psychological reactions to physical disorders while Social and Community psychiatry is concerned with social determinants of mental illness and with the provision of a coordinated programme of mental health to a specified population.

Other sub-fields include the addictions, eating disorders, intellectual disability and neuropsychiatry. The area of study of psychiatry thus includes a range of disorders that extend from those for which there are obvious brain abnormalities such as the various dementias through to deviations of personality development.

Mental health disorders are common

Over recent years there has been increasing awareness of the prevalence of psychiatric disorders within the community and its contribution to disability and mortality. WHO studies have shown that in 1990 around 11% of the total global burden of human disease was accounted for by mental illness and that this will rise to around 15% by the year 2020. In 1990 it was estimated that five of the ten leading causes of disability were psychiatric conditions – unipolar depression, alcohol misuse, bipolar mood disorder, schizophrenia, and obsessive-compulsive disorders; and mental illnesses were held to account for around 28% of all years lived with disability. Community studies both in New Zealand and overseas have shown that the six month prevalence of mental disorders is around 25% and 8-9% of the population have significant disability due to psychiatric illness. On a more personal level most of us have friends or family who will have received treatment for one of the psychiatric disorders and may also know of someone who tragically, has taken their own life, usually because of untreated or unrecognised psychiatric illness.

Where are mental health services provided?

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 will therefore present to and be treated by doctors in other branches of the profession, 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 involve multidisciplinary teams of professionals of 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, the investigation of 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 mental health diagnosis. As doctors we should be advocates 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 being separate. Patients with mental health problems have very high rates of physical health problems, and those with chronic medical conditions have very high rates of psychiatric disorders, which adversely affect their outcome.

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

Psychiatry is a complex specialty and may seem bewildering when first encountered as a student. It rewards practitioners who have a high capacity to tolerate uncertainty, a capacity for empathy, an awareness of their interpersonal boundaries, broad intellectual interests and who are appreciative of 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 don't hesitate to discuss any concerns you have during your attachment with your supervising consultant or cohort tutor.

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 principles of basic clinical psychopharmacology.
- Describe the principles of psychotherapy and other non-medical 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

- Evaluate patients presenting with a range of high prevalence as well as low prevalence but high risk psychiatric problems across different developmental stages e.g. childhood/ adolescence, adulthood, old age.
- Perform a formal psychiatric history and mental state examination.
- Present the findings of a mental state examination in a logical manner, both written and verbally.
- Synthesise and integrate information to formulate differential diagnoses.

3. Clinical decision-making

- Formulate a multi-axial diagnosis using DSM-IV.
- Develop a biopsychosocial management plan.
- Assess and properly manage safety issues.
- Identify the risk issues to be managed and include these in a plan.

4. Communication with patients and families

- Inform and educate patients and their families.
- Communicate with patients and families using a clear and sensitive approach.

Domain: Personal and Professional skills

5. Professional qualities

- Effective time-management and punctuality.
- Ability to consider ethical implications during decision-making.
- Awareness of the importance and role of good doctor-patient relationships.
- Capacity for critical thinking and constructive self-criticism.
- Using a developmental approach to clinical problems.

6. Engagement in team

- Constructive approach in collaborative working environments.
- Ability to engage with allied staff members from the multidisciplinary team from the public, community and non-governmental sectors.

7. Health and Wellbeing

- Ability to apply a range of approaches to maintain psychological, physical and overall well-being to self and others.
- Recognition of own limits.
- Reflective practice.

Domain: Hauora Māori

8. Critical reflection

- Identify key Māori health issues and explain the approaches to addressing the issues.
- Identify the strengths and areas for improvement in both 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 identifying their strengths.
- 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 the patient.

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 0800-1600hrs (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 cohort tutors. Details of the programme, topics and timing will be advised separately. You will have a weekly group session 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:

Central Auckland

Dr Emme Chacko | emmec@adhb.govt.nz

North & West Auckland

Dr Frederick Sundram | f.sundram@auckland.ac.nz

Mason Clinic

Dr James Cavney | James.Cavney@waitematadhb.govt.nz

South Auckland

Dr Eric Pushparajah | eric.pushparajah@middlemore.co.nz

Waikato

A/Prof David Menkes | david.menkes@waikatodhb.health.nz

Pukawakawa

Dr Joseph Chommy Kelly | Joseph.Kelly@northlanddhb.org.nz

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

Overall administrator for the course:

Saira Khan | s.khan@auckland.ac.nz

Year 5 Academic Programme Coordinator:

Dr Frederick Sundram | Email: f.sundram@auckland.ac.nz

Please remember:

- Dress responsibly; look the part of a respectable medical team member.
- Ask politely, smile, make good eye contact and you are more likely to be rewarded.
- Always ask patients whether they are prepared for you to be involved.
- Be proactive in asking to sit in during consultations, and continue to ask; busy staff may forget about you.
- Respect patient confidentiality at all times.
- Use computer privileges to access information relevant to your case(s) only.
- Advise your consultant about any absences or illnesses in advance.

Your time in Psychiatry is designed to:

- Acquaint you with a variety of psychiatric disorders.
- Accustom you to interviewing patients with psychiatric disorder.
- Teach you to carry out mental status examinations.
- Enable you to watch mental health professionals at work.
- Give you an opportunity to think about the interactions between biological, psychological, social cultural and spiritual influences in the 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 making services which respect and welcome Māori approaches to health and illness, so it is important that students understand these in their placements.

In 1982 Dr 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 seeing Māori clients 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 clients in this context.

For further information on Whare Tapa Whā model, see:

http://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha

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 or team. Also start preparing for the mid-way and end of run of assessments and start booking in times to meet with you consultant supervisor.

Week 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 night on-call work per week with your 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.

Start identifying a topic for your CAT. Aim to complete your first (formative) mini-CEX by the end of Week 3 or if not possible, by the middle of Week 4.

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 person from another service for a day if possible. Ask permission from the consultants involved before you swap with someone from another service.

Week 5 and 6

Consolidate your experiences in all areas. Complete your Clinical Experience Checklist. Continue to schedule weekly on-call experiences. Discuss your CAT with your team. Finalise your case history and organise a mini-CEX with your supervisor that is summative. 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 holding onto 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 a structure to provide 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 you are in a narrowly defined specialty area you should arrange visits to more general units via your cohort tutor. Do liaise with your consultant to make sure your arrangements fits with them.

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. Length of the case history should not be more than 3000 words. Anything longer will be awarded a fail grade. 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.
- **Critically Appraised Topic and presentation:** Your CAT should follow the format provided by the School of Population Health at the EPIQ website. It may consider aetiology, prognosis, diagnosis or treatment. You will present your CAT to your team/consultant. You only hand in the CAT marking sheet to your local administrator. Schedule your CAT presentation well before the actual date to make sure your consultant will be present to mark it.
- **Mini-CEX:** At least two mini-Clinical Evaluation Exercises: one (or more) formative, one at the end of your run on which you are graded. The formative Mini-CEX needs to occur half-way through the run, the second towards the end. 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 for medication side-effects. Other activities may also be negotiated.

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 in the Clinical Supervisor Report AND Case History AND Distinction in the CAT OR Mini-CEX
Pass	Minimum of Pass in the Clinical Supervisor Report AND Mini-CEX AND 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 AND CAT
Fail	Fail in the Clinical Supervisor Report OR Mini-CEX OR Fail in the Case History AND 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

MyPsychiatry - Coursebuilder, University of Auckland, MBChB portal (Webpage)

Oxford handbook of psychiatry (Book)

David Semple, Roger Smyth, 2013

Kaplan & Sadock's Comprehensive Textbook of Psychiatry (Book)

Kaplan & Sadock's synopsis of psychiatry: behavioral sciences/clinical psychiatry (Book)

Benjamin J. Sadock, Virginia A. Sadock, Pedro Ruiz, 2014

Managing children with psychiatric problems (Book)

M. Elena Garralda, Caroline Hyde, NetLibrary, Inc, 2003

Introductory Textbook of Psychiatry, Sixth Edition (Book)

Donald W. Black, Nancy C. Andreasen, 2014

Clinical interviewing (Book)

John Sommers-Flanagan, Rita Sommers-Flanagan, 2013

Classification systems (4 items)

Diagnostic and Statistical Manual of Mental Disorders: DSM Library (Webpage)

Diagnostic and statistical manual of mental disorders: DSM-5 (Book)

American Psychiatric Association, American Psychiatric Association. DSM-5 Task Force, c2013

Diagnostic and statistical manual of mental disorders: DSM-IV. (Book)

American Psychiatric Association, American Psychiatric Association. Task Force on DSM-IV., c1994

The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines (Book)

World Health Organization, 1992

Printed textbooks (4 items)

Kaplan & Sadock's synopsis of psychiatry: behavioral sciences/clinical psychiatry (Book)

Benjamin J. Sadock, Virginia A. Sadock, Pedro Ruiz, 2015

Book | Textbook | Print version available in Library

New Oxford textbook of psychiatry (Book)

Michael G. Gelder, 2009

Foundations of clinical psychiatry (Book)

Sidney Bloch, Bruce Singh, 2007

Stahl's essential psychopharmacology: the prescriber's guide (Book)

Stephen M. Stahl, Meghan M. Grady, 2011

Handbooks (1 items)

Oxford handbook of psychiatry (Book)

David Semple, Roger Smyth, 2013

Writing a psychiatric case history

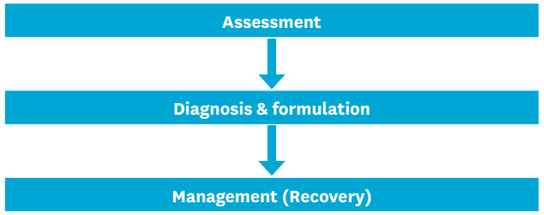
The clinical task and the clinical logic

Patients come to psychiatric services seeking (or their relatives hope) for some intervention(s) which would improve the way they feel, and/or the way they function. The key to this, and the whole point of the doctor/patient interaction, is to jointly develop a **patient management or recovery 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 drive 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.

Given the same assessment information, all clinicians should 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 drive the management plan and it should be possible to see a reason for everything which appears in the management plan, in the diagnosis and formulation.

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

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 at the end of the attachment as resubmissions will not be accepted
- Please discuss the case histories with your Consultant or Registrar before submitting it
- The case history should be a maximum of 3000 words, any case histories exceeding this limit will be returned to you and not marked
- The reflection/references are not included in the word count but the headings throughout the history are

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 – you must put age, gender, occupation and ethnicity. Do not guess the patient's race or cultural affiliation; ask this. You cannot practice psychiatry without understanding how the illness impacts on the individual's cultural world view or what it would mean to them about themselves or what the implications are for treatment alliance. In demography you may also wish to put number of children or living circumstances for example: "Mr Pearce is a sixty year old Caucasian widower who is a retired bus driver and lives with his only daughter" or "Mr Toto is a thirty year old Māori who lives with his wife and two year old son. He is a civil engineer." Immediately with a demographic statement the readers start to form a picture of the person as an individual.

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

This is a description of the **current complaints/symptoms/signs** that the person has. You are **narrating a story** here. Stories often have a beginning, middle and an end. Coherent stories have flow, a clear time line or chronology of events. It is very important that you attempt to answer the question of **"why now?" Mental and behavioural symptoms should be described in detail**. This requires detailed elaboration often using the persons' own words and supported by a relevant functional enquiry. Quote the patient but in a selective way so that information is going to support your mental state and diagnosis and be consistent with the theme of the case e.g. "John describes both male and female voices talking about him. They say insulting statements such as "he has a hideous nose; no wonder everybody thinks he's a freak." With an important piece of history like this you must tag on relevant negatives e.g. "the voices do not tell or command John to do anything."

It would be helpful if the **identified mental/behavioural symptoms** (i.e. low mood, voices, suicidal thoughts) are **qualified in terms of a) onset b) duration c) precipitating or mitigating factors d) severity**. For example, "Chris has had on and off thoughts of ending his life for about 2 years now. It started after he separated from his partner. He noticed that every time he drinks alcohol, for the next 48 hours, these suicidal thoughts increase. On the other hand, when he spends time with his children, the thoughts seem to melt away."

If you have someone with psychotic symptoms you must present a relevant functional enquiry e.g. look for common delusions such as persecutory, thought interference and delusions of reference. In the history of presenting complaint section, this should be detailed and must include the patients **attribution** of their experiences for example "John believes the voices come from the devil as a result of a voodoo curse put on him by his neighbours." Attribution should also cover cultural understanding of illness. The history of presenting complaint must also include **impact** of illness on functioning, for example "John has left home in fear because he experiences the hearing of voices when alone and is now homeless. He has also dropped out of his Unitec course and has no contact with either family or friends." This impact statement shows the examiner that you are familiar with the concepts of disability and impairment. A common criticism is that doctors can elicit symptoms but make no sense of them in terms of the individual's life experiences. Key areas to ask about include activities of daily living, social functioning and effects on cognitive tasks such as concentration and learning. Another key area is **coping** - how does the individual cope with their experiences – later it can be discussed in the formulation whether this is protective or not e.g. "Jack copes with the voices by drinking alcohol which he feels reduces their intensity" or "Jane copes with her feelings of being unreal by ringing her mother. If her mother is not available she cuts her wrist with a scalpel which she says helps her feel focused."

Current medication/interventions, duration of treatment, efficacy and side effects should be documented.

Current neuro-vegetative signs and symptoms have to be included. These are sleep, energy, concentration, ability to experience pleasure, appetite and libido.

A common problem that medical students experience is how to write up the history of presenting complaint in the person seen in a community mental health setting. The key is to start with their current well-being and not when they were referred several years ago. The details of the referral from several years ago are part of the person's past psychiatric history. If someone is seen as an inpatient, it would be necessary when the person was seen along their recovery pathway and also management that has occurred so far.

One of the most common mistakes students make is the lack of elaboration of symptoms and signs. They simply report a symptom/ sign/ event without proper elucidation or enquiry. Examples are:

"Maria felt quite bad that she overdosed and was then hospitalised." End of paragraph.

With this report, any inquisitive student will ask details about the following:

1. Why was she feeling bad? How long has this been going on? Any specific triggers? How frequent is this? Is this a recurring pattern?
2. Overdosed with what? Has she done this before? Is this a recurring pattern? Was there someone present when she did this? Was it impulsive or was it planned? Did she do it in a place where she can be found easily or did she hide herself to prevent rescue?
3. How did she end up in the hospital? Did she actually call 111 or did she call her partner/family? Was she found unconscious? What is her attitude to being in hospital?

As you can see from this example, **simply reporting events is not enough** when one writes the History of Presenting Complaint. You are reporting in detail the background story behind the symptoms/signs which inform the subsequent management plan. For example the amount of planning that Maria made for her overdose will determine some aspects of the management plan.

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 abuse 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

If this is extensive, summarise the pertinent points. Exact dates are less important but treatments received, responses and serious events leading to hospital are. If no past attempts at harming self or others say this. If there are, provide details e.g. "John has had at least ten hospitalisations over the last six years with what appears to be an exacerbation of his schizophrenia. On one occasion he had a serious suicide attempt where he jumped in front of a car and fractured his hip in response to command hallucinations. He tells me he has been on a number of medications including chlorpromazine, haloperidol, pimozide and an injectable antipsychotic. He also describes frequent side-effects such as tremor, impotence and akathisia. He does not believe that the medicine treats his voices but only dampens them down".

By presenting the past psychiatric history in this way, you have directed the key issues that you can raise both in formulation and management namely, treatment-resistant psychotic symptoms and forming a therapeutic alliance with a disengaged high-risk patient with frequent relapses. It is important for the management plan to inform on what the key issues are, what has worked, what hasn't worked and why things have or haven't worked in the past.

Do mention whether there have been episodes of care under the Mental Health Act or whether continuing on a community treatment order. Explore whether relevant counselling and psychological modalities have been used and what have the responses been to these.

Medical history

Use common sense and to provide details for the most relevant parts for example, don't write in detail on an appendicectomy that is likely to be of no rel evance. However, a diagnosis of diabetes in a man with schizophrenia is highly relevant given that atypical antipsychotics can significantly worsen glycaemic control and would require detailed discussion. Key points are physical illnesses and their treatment either presenting as a mental illness 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. For example, this is of major importance if you get a young person who has had a chronic or severe physical illness throughout their life. 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) and include 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 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 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. 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."

Personal history

Personal history to encompass: Developmental (including perinatal period and early development, education and work), Psychosexual and relationships, Substance abuse 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 returning to work is often an important management goal.

2. Psychosexual and relationship history

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 number of overall relationships, the quality of relationships and whether there may be difficulties in maintaining a relationship or 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 tends to be controlling. They have no children and Ann feels vulnerable in this relationship and wished she had seen other men before settling down."

3. Substance abuse history

It is important to not only quantify amounts of substances but show the distinction between abuse and dependency by relevant positives and negatives. If the case is clearly a substance abuse one, the substance abuse history should be presented in 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 that a common omission by students is that after detailing a significant substance abuse/dependence, they forget to include it in their multi-axial diagnosis. Remember, it is part of Axis 1 disorders.

4. Forensic history

It is useful to provide details relating to any contact with the Law including previous charges/sentencing/pending trial/etc. Also, should mention if they've had any suspended/community/custodial sentences. For example "Janet has had one arrest for dangerous driving when she was manic." Always mention even if negative - "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 stability, 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 even future events and treatment.

It is generally not good 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 situations.

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 on any benefits? What is the patient's 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. A helpful mnemonic is **BOATPIS**

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; don't just say good or bad but elaborate on it. Describing why rapport was bad doesn't mean that you are necessarily a bad Dr rather that you are a reflective Dr with a conception about dynamics.

Finally, note your own observations about a person's behaviour as well as your reactions to them during the interview (e.g. the engaging or uncomfortable dramatic style of communication of someone who is histrionic and flamboyant or the irate response you have to an over-inclusive obsessional person in a setting which is time-limited)

DO NOT BLAME THE PATIENT OR MAKE DEROGATORY REMARKS ABOUT THEIR APPEARANCE

Orientation/Cognition

Present a Montreal Cognitive Assessment (MOCA) with frontal lobe bedside testing (where relevant). If there are no abnormalities, this can be done quickly e.g. "no abnormalities were detected on a MOCA or on tests of frontal lobe function." If there are any cognitive abnormalities, this is always relevant and you have to say what tests were abnormal. For example: "Mrs Jones scored 24/30 on a Montreal Cognitive Assessment. 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. Her ability to describe similarities between an orange and a banana was impaired after saying they were both fruits and she was unable to generate further ideas. On proverb interpretation, she was concrete and when asked the meaning of "too many cooks spoil the broth" she told me she had a small kitchen where not many people would fit in."

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 or whether there are loose associations such as the patient moving from one topic to another. Giving examples helps.

Thought content

Comment on delusions, ruminations/obsessions or overvalued ideas if they are present. Describe what the person is actually saying to you e.g. "Tom spoke in a self-deprecatory manner outlining his many failures although this was neither delusional nor ruminatory in nature." 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 psychiatric disorder. Command auditory hallucinations are associated with an increased risk of harm to oneself and to others, so should always be explored and mentioned 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 seen 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).

Insight

This has several parts:

1. Does the person think that something different is going on, i.e. they see the symptoms as...
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.

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

It is important to explore what the potential risks are such as risks to self or others; risk from others; risk of self-neglect; etc.

When clarifying risk to self as part of a suicidal risk assessment, some elements may be covered previously under Thought content. Areas to explore include experiencing a passive death wish e.g. would rather have a terminal illness like cancer and pass away without any active help. Hopelessness for the future is a major predictor of future self-harm and suicide and should be explored. Suicidal ideation, intent and planning are further areas to explore

Physical examination

Keep this brief and tailored – in psychogeriatric cases, 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 36.5oC. 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, 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

A formulation is more than a summary. It is your opportunity to define how you understand why this person is presenting with this problem at this point in time. Writing a formulation requires knowledge of facts about the person as well as some knowledge of pertinent theories. Don't worry too much about the latter - your Registrar or Consultant will be able to help you with them.

Different schools of psychotherapy use different types of clinical formulations, however, the most popular form used by clinical services these days is called the "Bio-Psycho-Social model" in which the following areas ("the 5 Ps") are presented using a combination of biological, psychological and social 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).
- 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).
- 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 IV (DSM-IV) or the International Classification of Disorders 10 (ICD-10). Present your primary or most likely diagnosis as well as other possible differential diagnoses. Justify diagnoses on the basis of DSM or ICD criteria and why you ruled in or out diagnoses. You should use the multi-axial system that is present in DSM-IV to cover all diagnoses when using this classification system including current as well as historical diagnoses.

Management Plan

This section includes considerations that cover that cover BOTH Investigations and Treatments. The Management plan covers what you would consider doing in the context of access to unlimited resources and not necessarily what occurred with the actual management of the person.

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 abuse 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 crisis. An active plan to address substance abuse 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 system for years with an unclear or inconsistent diagnosis. Too often, diagnoses like schizoaffective disorder are used in a loose and meaningless way to justify unfortunate polypharmacy. Management addressing differential diagnoses includes reviewing old notes both psychiatric and medical, obtaining a thorough longitudinal history from the individual and meeting with family members to gain collateral information for clarification.

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 English is not their first language.

4. Biological management

a) Pertinent diagnostic tests and examinations

Consideration of the physical health of the individual is essential. This is because physical conditions may present with an altered mental state e.g. delirium. Another important reason is because of the possible interactions with pre-existing medicines taken for a physical condition.

It is important to establish baseline blood tests prior to prescribing many medications e.g. renal function and thyroid function prior to commencing lithium treatment. Also, Na+ levels should be monitored in the elderly when considering antidepressants such as SSRIs.

Additionally, there are drug plasma levels that can be tested such as Lithium, Valproate and Clozapine levels as part of monitoring. 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 General Practitioners.

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 cognitive disorder affecting the elderly. ECG should be conducted as a matter of routine prior to commencing psychotropics and while on psychotropics to monitor for arrhythmias such as prolonged QTc. Further, a urine drug screen should be performed when attempting to rule out the use of substances.

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:
www.medsafe.govt.nz

Though not a medication, ECT for conditions such as resistant depression or when a rapid response is desired, should be considered.

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 a number of 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 relaxation techniques and breathing exercises for anxiety, 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 their housing relates to their ability to maintain wellness in the community. 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

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.

Reflection and references

Reflection

In asking students to write case histories, we do not just expect them to be "scribes". We encourage critical thinking and reflection. In this section of the Case History, we want you to reflect on what you have learnt from this case. For example, this may include the impact it has had on you.

References

Provide the references you used for arguing your use of certain management strategies or other parts of the case history where you alluded to the literature e.g. clozapine for treatment-resistant schizophrenia or ECT for depression.

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, monotonous, mutism).

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 (repletion 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

Tips for psychiatric interviewing and screening questions

Introduction to Psychiatric Interviewing

Important components of the interview:

1. Content (gathering information, essentially a list of clinical questions).
2. Process (how you connect with the patient during the interview through verbal and non-verbal techniques).

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, avoid solely focusing 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. The FIVE neuro-vegetative signs and symptoms (quality of sleep, energy, concentration, appetite, libido).
5. Past Psychiatric History (Previous diagnosis, medications, psychotherapy and hospitalizations).
6. Medical History (current medications, active or past medical and surgical conditions and allergies).
7. Developmental History (patient's childhood experience, history of trauma and positive relationships).
8. Drug & Alcohol History (masquerades as many psychiatric conditions, important to rule out 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 Status Examination.

Three types of interview questions

1. "Big net" questions (usually open-ended questions that explores 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. Five 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 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 10-20 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 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 extremely 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, have rituals?)
7. Post-traumatic Stress: Have you been in some kind of traumatic life 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 with you? Hear things when nobody's there? [Auditory] See things that you know aren't real? [Visual] What do the voices say? 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? [referential delusions]

Alcohol & Substance Use

1. Alcohol abuse: specify number of units per week.
   - Specific questions to ask around abuse: C.A.G.E. = Cut back; have you had thoughts of cutting down on drinking? Anger; have you been angry when people talk about your drinking? Guilt; have you felt guilty about the amount your drinking or how your drinking? Eye-opener; has it reached a point where you have to drink in the morning to feel normal?
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 HEEEADSSS)

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?

References:

1. Goldenring, J, Cohen, E (1988) Getting into adolescents heads. Contemporary Pediatrics, July: 75-80.
2. Cohen, E, MacKenzie, R.G., Yates, G.L. (1991). HEADSS, a psychosocial risk assessment instrument: Implications for designing effective intervention programs for runaway youth. Journal of Adolescent Health 12 (7): 539-544.

Appendix 5

Montreal Cognitive Assessment (MOCA)

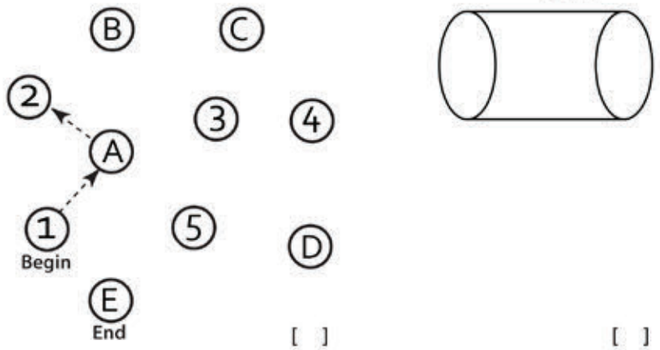
Montreal Cognitive Assessment (MoCA) Version 3 Administration and Scoring Instructions found here: **http://www.mocatest.org/**

MONTREAL COGNITIVE ASSESSMENT (MOCA)
Version 7.3 Alternative Version

NAME : **Date of birth :**
Education : **DATE :**
Sex :

VISUOSPATIAL / EXECUTIVE — POINTS

Copy cylinder

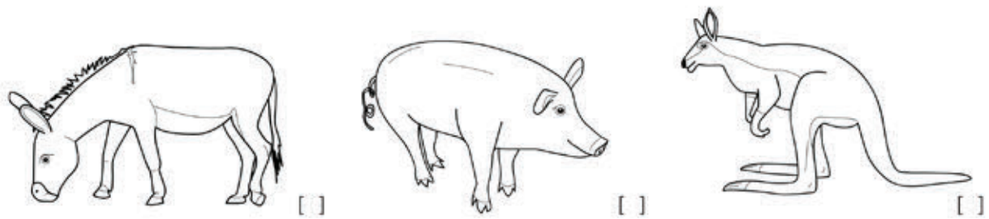


[ ] [ ]

Draw CLOCK (Ten past nine)
(3 points)

[ ] Contour [ ] Numbers [ ] Hands __/5

NAMING



[ ] [ ] [ ] __/3

MEMORY Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	TRAIN	EGG	HAT	CHAIR	BLUE
1st trial					
2nd trial					

No points

ATTENTION Read list of digits (1 digit/ sec.).
Subject has to repeat them in the forward order [ ] 5 4 1 8 7
Subject has to repeat them in the backward order [ ] 1 7 4 __/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B __/1

Serial 7 subtraction starting at 80 [ ] 73 [ ] 66 [ ] 59 [ ] 52 [ ] 45
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt** __/3

LANGUAGE Repeat : She heard his lawyer was the one to sue after the accident. [ ]
The little girls who were given too much candy got stomach aches. [ ] __/2

Fluency / Name maximum number of words in one minute that begin with the letter B [ ] _____ (N ≥ 11 words) __/1

ABSTRACTION Similarity between e.g. banana - orange = fruit [ ] eye – ear [ ] trumpet – piano __/2

DELAYED RECALL __/5

	Has to recall words **WITH NO CUE**	TRAIN [ ]	EGG [ ]	HAT [ ]	CHAIR [ ]	BLUE [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City __/6

Adapted by : Z. Nasreddine MD, N. Phillips PhD, H. Chertkow MD
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Normal ≥ 26 / 30

TOTAL __/30
Add 1 point if ≤ 12 yr edu

Administered by: _____

Appendix 6

Guidelines for Psychiatry Registrars: how to help your student meet their learning objectives (please show this to your placement registrar or house officer)

First, thank you for your help!! Although teaching is an expected part of a registrar's role we do understand that it can be time-consuming to work with medical students. You are a role model; research on student learning shows that registrars and house officers greatly influence clinical learning for medical students, so we hope that you will find their presence interesting, rewarding and a challenge!

Students may take a while to find their feet: please encourage them to take part in clinical activities as much as possible. They have a Clinical Experience Checklist which they need to complete, please ask them to show you this if they do not approach you so that you can help them focus their experience.

Each student is expected to see as many patients as possible during this time.

The students are expected to submit a case history based on one long case during the attachment. They are also expected to complete one Critically Appraised Topic and present this, sometimes to a Journal Club or allocated team, otherwise to the Consultant or registrar. In addition, they have two mini-Clinical Evaluation Exercises (mini-CEX): the first is a formative assessment, the second contributes to their final grade.

By the conclusion of the run it is hoped that all students will be conversant with history taking and Mental state examination. Planning their cases to be written directly into the patient notes under registrar/HO supervision and long case submission (to be discussed with the supervising consultant before the end of the attachment) should allow this to be achieved.

The responsibilities of the Registrar are:

- To befriend the students so that they feel welcome on the ward.
- To guide the students to patients with interesting symptoms and signs.
- To contribute to teaching as requested by cohort tutors.
- To help them feel involved with routine team activities, students should assist with admissions/new assessments if time is available.
- To notify the consultant, co-ordinator for your location and/or Dr Frederick Sundram, Academic Coordinator for Year 5 students (f.sundram@auckland.ac.nz) of any student who may be experiencing difficulties in their clinical work or poor attendance.

We know from experience that the Registrar can greatly enhance the students' ward experience. Remember the House Officer and Trainee Intern (if the ward has one) should also assist with student teaching.

Early in the year, students occasionally say "we aren't sure what we are meant to do on the rotation" - the answer is "to see as many patients as possible and to participate fully in team activities, without disrupting clinical work or patient care". The Registrar/House Officer is the person who should give guidance as to how this can be achieved.

There is more information on quick and useful teaching methods here: **https://www.fammed.wisc.edu/med-student/pcc/preceptor/resources**

Thank you again.

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

Contact

Department of Psychological Medicine
Faculty of Medical and Health Sciences
The University of Auckland
Private Bag 92019
Auckland 1142
New Zealand

Phone: +64 9 923 6751
Email: Saira Khan | s.khan@auckland.ac.nz
Web: www.fmhs.auckland.ac.nz

www.fmhs.auckland.ac.nz/psych-med