Core skills in assessment of mental health problems
in the general hospital setting

Session overview

Module: Mental Health skills for non-mental health professionals

Description: This session provides a framework for establishing good communication in the general hospital setting which will provide the basis for the skills developed in the optional module ‘Mental Health skills for non-mental health professionals’

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Learning objectives

By the end of this session you will be able to:

- Recognise why good communication skills are important for assessment of mental health in the general hospital setting
- Recognise the challenges involved in communicating effectively in a busy general hospital setting
- List the key skills required when assessing the mental health of a patient
- Outline the core elements of establishing good rapport with a patient
- Define some key interview skills that are essential to effective assessment of mental health
- Understand the basics of history taking and mental state examination
- Understand the basics of risk assessment and risk management
- Ask for more specialist help appropriately
Introduction

Psychological distress and mental health problems are very common in general hospital patients and can impact negatively upon quality of life and health outcomes. Assessing the mental health of medical patients is very important but often overlooked in a busy hospital setting. This session offers an opportunity to review and develop skills in mental health assessment that are essential in establishing a therapeutic clinician-patient relationship, gathering appropriate information, assessing risk and communicating this information to relevant people in order to initiate appropriate management. The skills covered in this session need not be time consuming, can be incorporated into everyday practice and used well are likely to improve patient care and outcomes.

Overview of skills covered in this session:

- Establishing rapport
- The basics of good interview skills
- Taking a history
- The basics of mental state examination
- Risk assessment
- Communicating with colleagues and asking for help
**Establishing rapport**

Good communication skills underpin a good mental health assessment. The key to establishing communication is developing a rapport. Rapport is a sense of understanding between individuals and ‘being on the same wavelength’.

The list below gives examples of factors that can interfere with good establishment of rapport:

- Busy room/hospital cubicle
- No privacy
- Noisy
- No proper introduction, fiddling with equipment, disorganised
- Dress inappropriate to the occasion
- Doesn’t ask if visitors should remain in the room
- Stands to talk to the patient
- Not asking the patient how they want to be addressed
- Lots of obvious distraction (e.g. phone rings, bleep goes off etc)
- No ice breaker, impolite, gets basic details wrong
- Poor eye contact, no impression of being interested
- Starts writing notes which interfere with communication
- No acknowledgement of how the situation must be for the patient
- Asks personal questions with little preparation

In a busy general hospital it can be difficult to find a suitable private place for a patient interview but it is important to try to provide the best conditions possible to ensure privacy, quiet and confidentiality.
Establishing rapport 2

There are a number of things you can do to put the patient at ease and help to establish a good therapeutic relationship. You should consider these factors each and every time you see a patient and in time they will become second nature.

- Set the scene
  - Check that the environment is suitable for a patient interview or try to find somewhere quiet and free from distractions
  - Eliminate any obvious distractions in the immediate environment as far as possible
  - Provide a safe private space (close the curtains, tell other staff members that you are going to speak to the patient and ask not be disturbed unless unavoidable etc)
- Introduce yourself using your name, title and designation
- Ask the patient how they would like to be addressed
- Don’t assume that the patient wants to talk to you in front of visitors who may be present. Give them the option of asking the visitors to leave if they wish.
- Be aware of your presentation, body language and demeanour.
  - If you are not wearing a hospital uniform then be conscious of how your clothing may be perceived by the patient.
  - Be polite and respectful regardless of who the patient is.
  - Use eye contact appropriately: Make eye contact and maintain it intermittently. Be aware that some patients may find constant eye contact intimidating.
  - Sit so that you are at eye level with the patient
  - Be aware of your physical presence and how this might impact upon the interview. Sitting directly opposite the patient may feel interrogatory: consider sitting at 45 degrees to the patient.
  - Be aware of cultural factors which might impact upon the interview including ethnicity and language. It may become clear that an interpreter is required, in which case it may be appropriate to postpone the interview until an interpreter can be booked.
- Explain why you have come to see the patient and how long you anticipate spending with them.
- Reassure the patient about confidentiality but be clear about whom information may be shared with.
- Let the patient know if you are planning to make notes and what these are likely to be used for.
- If you plan to talk about a sensitive topic acknowledge the potential for distress and explain why you wish to address a particular topic if you anticipate that it may be upsetting.
**Interview skills**

A patient interview involves an exchange between clinician and patient. The clinician and patient may have different expectations of what the interview will involve and what will be achieved from it. It is important therefore to try to acknowledge both your need for information and satisfy the patient’s expectations of the interview. The diagram summarises the information gathering components of a patient interview.

Below the diagram are explanations of the terms used.

**Open question**: A question which has a wide potential for response and allows the patient the freedom to give information.

**Example 1:**

*Question*: How have you been feeling in yourself?

*Response*: It’s difficult to describe; I haven’t felt like myself for a few months etc....
Follow up question: After the patient has had an opportunity to respond to the question, you may wish to ask for further information which again allows the patient to expand.

Example 2:

Question: You said that you haven’t been feeling like yourself for a few months—could you tell me more about that?

Response: Well I’ve been feeling low for a while and I can’t seem to get myself out of it. I also feel quite panicky like something is about to go wrong. I can’t stop crying and I can’t sleep and I have to make myself eat because I don’t feel like it any more.

Closed question: Once you have a good idea of what the patient is experiencing, you may then wish to ask some further specific questions to gather more detail. Closed questions have limited potential for answers.

Example 3:

Question: You said that you can’t sleep—are you finding it difficult to get off to sleep?

Response: Yes.

Question: How long does it take you to drop off?

Response: Often about 2 hours

Question: Do you wake earlier in the morning than usual?

Answer: Yes, I would normally wake up at about 7am but lately I wake up at about 4am and can’t go back to sleep.

Summarise and check your understanding: It is important to check that you have understood the information correctly and to do this at several points during an interview before summarising at the end of the interview. This need not take up much time and gives the patient an opportunity to correct any misunderstanding and add relevant information.

Example 4:

Example: So you’ve told me that for the past two months you’ve been feeling low in mood, anxious and tearful. You cry most days, have difficulty sleeping and you’ve lost your appetite. Have I got that right?

Response: Yes, that’s right. I think I’ve been feeling much worse for the past two weeks though and in the past few days I’ve been starting to think about whether life is worth living.
History taking 1

Learning to take a good history is a skill that comes with experience and practice. Different specialties will concentrate more on certain elements of the history, and in a mental health assessment there is a greater emphasis on psychological symptoms and experiences and the factors that contribute to and influence these experiences.

In this course you will become familiar with elements of the psychiatric history especially as they relate to people with co-existing physical disease.

When a symptom (e.g. panic) is presented, there are some key generic questions that will help you to define and describe the symptom and its associated factors:

**Nature**
- What does (the symptom) feel like?

**Course**
- When did it start?
- Is it there all the time/intermittently?
- How often does it happen?
- Does it happen at a particular time of day/is it predictable?
- Does it ever go away completely?

**Severity**
- How is it at its worst?
- Is it worse/better at particular times of day?
- How does it affect your life/job/relationships?
- Have you had to stop any activities because of it?

**Associated factors**
- Can you identify anything that caused [the symptom] initially?
- Is there anything that seems to trigger [the symptom]?
- Are there any other symptoms that seem to be related or happen at the same time?
**History Taking 2**

Patients present to the general hospital in a great variety of ways with a wide diversity of problems. You may be used to seeing patients in an outpatient clinic setting, on the ward, in accident and emergency or in the community. Some patients who present primarily with a physical illness will also have significant psychological distress and those who present with psychological distress may have a considerable burden of physical illness.

There are a number of elements that are important in the history. The following diagram outlines the key elements of a history. Below the diagram you will see more detail about each one.

- **Presenting problem(s)**
  - This is a brief description of the current problem according to the patient and the duration of the problem e.g. a 3 month history of feeling low in mood with increasing thoughts of suicide for the past 2 weeks.

- **History of the presenting problem(s)**
  - This section expands upon the presenting problem and includes the information on history taking on P10 and covers the following information:
    - When did the problem start?
    - What was the happening in the patient’s life when it started?
    - What are the symptoms of the problem?
    - How is it affecting the patient’s function, quality of life and relationships?
    - What makes the problem worse/better?
Past medical history

In a general hospital setting the patient is likely to be presenting primarily with a physical health problem. It is important to take a detailed history of how past and current physical health problems relate to the mental health problems as symptoms such as pain can worsen psychological distress and likewise psychological distress can have negative impacts on physical symptoms.

Past psychiatric history

Previous episodes of mental illness (whether formally diagnosed or not). This will include:

- Type of illness (diagnosis of given)
- First onset
- Number and duration of episodes
- Severity of episodes (admitted to hospital? Detained under section of the Mental Health Act?)
- Previous treatment and effect of this treatment
- Previous and/or ongoing contact with mental health services

Current medications

Try to compile a detailed list of current medications including non-prescribed (over the counter) medications and complementary/herbal medicines.

Include doses and mode of administration (e.g. oral/depot) and if possible how long the patient has been taking the medications.

Current social situation

This allows assessment of a patient’s individual circumstances and may include:

- Place of residence and whether own home/council property/residential accommodation/nursing home etc
- Current occupation status
- With whom does the patient live (if anyone) and what is their role
- Details about children (especially if dependent)
- Social support available/social life
- Other carers
- Social services/other statutory services involvement
- Income including benefits
- Hobbies and interests
- Any major difficulties at present e.g. debt, threat of eviction
Family and personal history

It may not be practical to take a full family and personal history from the patient but some of this information may be highly relevant to the current problem and will help in making a diagnosis and formulating a management plan.

If the presenting condition is known to have a genetic predisposition (e.g. Huntington’s disease) then a family history will be very important. Family history can be displayed as a ‘family tree’ <link to family sample tree>

The personal history may include:

- Any obstetric complications
- Circumstances of birth (e.g. complicated birth requiring neonatal ICU admission)
- Family circumstances in early life
- Early milestones (e.g. age of first walking or talking)
- Early schooling including school attainment
- Significant events in early life (e.g. bullying, sexual abuse)
- Educational achievements
- Sexual development
- Leaving home and gaining independence
- Travel
- Occupational history
- Relationships
- Children
- Other significant life events

Drug and alcohol history

It is important to ask about drug and alcohol use even if the person does not ‘seem’ to be someone who would use substances. Drug and alcohol use are related to many physical and mental health problems.

It is especially important to look for features of addiction or withdrawal from alcohol or drugs as these will need to be addressed.

Ask about drugs specifically as some patients may not think of the substance they are using as a ‘drug’ e.g. smoking cannabis

Also try to find out if the patient has any dependence on drugs that are not ‘recreational’ e.g. painkillers

For each drug used find out:

- When it started
- How much is used
- How often it is used
- Whether there is physical dependence on the drug (more information about this in the session on alcohol and substance use)
- Any attempts to stop and the success of these attempts
- Any health complications as a result of using the drug/alcohol

Forensic history

This relates to contact with police and prison services and can be helpful in building a picture of risk.

Areas to enquire about if relevant are:

- Criminal record
- Previous offences
- Custodial sentences
- Drink driving convictions of there is an alcohol history
- Any pending court cases or convictions
History taking 3: Other sources of information

Sometimes it will be difficult to obtain information from the patient themselves. They may be temporarily unable to give information or may have a condition that impairs communication e.g. dementia. Even if the patient is able to communicate it is often helpful to gather information from other sources to help build up a full picture. People close to the patient may have different perspectives on the problem and may be able to provide helpful information.

Below is a list of information sources that are likely to be useful:

- **Written information**
  - Medical notes
  - GP files
  - Reports
  - Legal documents e.g. advanced directives

- **Information from involved professionals**
  - General practitioner
  - Community services e.g. social services, community psychiatric services
  - Carers
  - Other statutory organisations

- **Information from family/friends**
  - Carers accounts
  - Family and friends' perspectives
Mental state examination 1

Mental state examination is the ‘psychiatric’ equivalent of the physical examination. Whilst the history is used to gather information about the patient leading up to the time you assess them, the mental state is a snapshot of how they are at the time they are assessed. Much of the information you need for the mental state examination is gathered while you are taking the history because it consists of observations about the patient. You may need to ask some additional questions to complete the mental state examination.

The following diagram shows the key elements of the mental state examination. The information below the diagram gives more detail:
Appearance and behaviour

These are observations that you make about the patient. The limits of ‘normal’ are wide but some features may point toward the presence of psychiatric disorder. The following list is not exhaustive but presents some broad areas to consider.

- **Appearance:**
  - Is the appearance broadly that expected for somebody of that gender/age/culture/ethnicity? If there is something unusual or unexpected about their appearance, what is it?
  - Is there evidence of poor self care/self neglect?

- **Behaviour:**
  - Is there any evidence of abnormal behaviour e.g. inappropriate personal boundaries, embarrassing behaviour, or reacting to things you are not able to see or hear?
  - Are there any movement abnormalities e.g. being very slowed down in movement (as might be seen in Parkinson’s disease) or restless and agitated (as seen various conditions including anxiety, mania, drug intoxication etc)
  - Are there any odd or inappropriate uses of eye contact, facial expression or gesture?

Speech

Abnormalities in speech can have a variety of causes including hearing impediments, neurological disorders, brain injury, structural impairments to the mouth and respiratory system and psychiatric disorders. Different disorders produce different types of speech abnormality and some are very typical of certain types of disorder e.g. the ‘Donald duck’ speech sound of patients with pseudobulbar palsy.

In psychiatry, description of speech can be divided into two main headings:

- **Flow**
  - What is the rate of the speech e.g. slow, hesitant, fast, pressured (fast and difficult to interrupt or stop)
  - What is the tone of the speech e.g. flat and monotonous or very animated?
  - What is the volume of the speech e.g. very quiet or loud?

- **Form**
  - Because our access to people’s thoughts is through their speech, any abnormalities of the ‘form’ of thought are heard in speech. There are many different types of ‘formal thought disorder’ but broadly these relate to how coherent the speech is and if lacks coherence, what is abnormal about it.
Mood

Variations of ‘normal’ mood can be very wide and should be assessed in context, for example, somebody who has been waiting to be seen in an overrunning outpatient clinic for three hours may reasonably be feeling angry and frustrated. Mood states may be described as abnormal when they are persistent, and/or detrimental to function, quality of life and relationships.

Mood states can be described under two main headings:

- **Subjective mood state:**
  - This is how the patient describes their own mood. For example feeling ‘blue’ or ‘worried’ or ‘despairing’

- **Objective mood state:**
  - Based on your assessment of the patient you are then able to describe their mood state. For example in a person who has features of depression you might describe them as low in mood with reduced energy and reduced capacity for enjoyment (anhedonia). Other features e.g. feelings of guilt, worthlessness, hopelessness and suicidal thoughts may be present. They may have physical manifestations of depression e.g. reduced libido, poor sleep and poor appetite and may have associated features e.g. poor concentration and reduced motivation.

Thoughts

This section is best described as thought content as thought form is described under the heading of speech. Questions to consider here are: what are the predominant themes in their speech? Are the thoughts consistent with what is happening to them? Is the content odd or bizarre?

The patient may be experiencing delusional thoughts: these are false ideas which are out of keeping with their cultural background or experience and remain despite evidence to the contrary.

The content of delusions is very variable but can range from frightening and persecutory (e.g. believing that the nurses are going to put poison in the medications) to grandiose (e.g. believing that you have special powers or have a special mission). Delusions are often mood congruent e.g. somebody who is very depressed may believe that a part of their body has died or that they have done something terrible and deserve to be punished.
Perceptions

Perceptions are sensory experiences and occur in the modalities of **hearing, vision, touch, taste, small and movement**. Abnormal perceptions may be experienced in both physical illness (e.g. people who have had amputations often experience sensations in the amputated limb) and mental illness (e.g. people with schizophrenia may hear voices when there is nobody talking), and there is some overlap between the two. Abnormal perceptual experiences, especially visual phenomena, are common in **delirium**.

Abnormal perceptions can be broadly categorised into **illusions** and **hallucinations**.

- Illusions are abnormal perceptual interpretations of actual stimuli e.g. seeing a shadow on the wall and thinking it is a monster.
- Hallucinations are perceptions with no stimulus e.g. hearing voices when there is nobody talking or feeling insects crawling under the skin when there is no infestation.

Cognition

Cognition or ‘thinking function’ and can broadly be broken down into **orientation, memory, language and visuospatial ability**.

Cognition can be affected by a number of conditions. Cognitive disorders can be developmental (present from birth or early life) or acquired (e.g. dementia or delirium). Cognitive deficits may be transient (e.g. concussion after a head injury or acute alcohol intoxication) or enduring. They may be progressive (e.g. in dementia) or stable.

There are a number of ways of assessing cognitive function but the most commonly used tools are the **Abbreviated Mental Test Score (AMTS)** and the **Mini Mental State Examination (MMSE)** which both use a standard set of questions to assess the main cognitive domain.

Insight

This is a complex concept that broadly relates to a patient’s understanding of their illness. It is relevant when it comes to considering whether a patient is able to consent to treatment. Assessment of insight is particularly relevant if the patient is suffering from a psychotic disorder e.g. schizophrenia or mania.

The following questions may be helpful when thinking about insight:

- Is the patient aware of the phenomena other people have observed?
- If they are, do they recognise them as abnormal?
- If they recognise them as abnormal do they attribute them to a mental illness?
- If so does the patient think that this illness needs to be treated?
Risk assessment 1: Managing personal risk in interactions with patients

A key priority in interactions with patients, whether or not there is a known history of risk to others is maintaining your personal safety at all times. The majority of people who behave in a violent or other inappropriate way toward others have no diagnosed mental disorder, so it is worth bearing your personal safety and boundaries in mind in interactions with all patients especially if you are meeting them for the first time.

The following diagram highlights some basic measures you can take when seeing patients which will help you to maintain your personal safety. More detail is given below the diagram:

- Identifying factors in advance that may increase risk
  - Does the patient have a known history of violence/inappropriate behaviour toward others?
  - Does the patient have a diagnosis that might increase their risk of impulsive/unpredictable behaviour?
  - Is the patient confused or disorientated?
  - Is the patient angry or irritable?
• **Basic safety measures prior to seeing a patient**
  o Always tell somebody where you are and how long you are likely to be there
  o If you are aware of a potential risk then attempt to modify this prior to seeing the patient e.g. if you are female and the patient is known to have behaved inappropriately with females then arrange to see the patient with a male colleague.
  o Try to use a room/place that you are familiar with, know the exits from and know how to access help from if needed.

• **Basic safety measures whilst seeing a patient**
  o Try to position yourself so that both you and the patient have an unobstructed exit route from the room
  o If you feel uncomfortable/intimidated/unsafe then leave the room as soon as you are able and seek assistance.

• **Maintaining personal boundaries**
  o Be wary of giving out personal information especially phone numbers, your address, where your children go to school etc.
  o Be aware of your personal space and physical contact with the patient
  o Do not tell the patient anything about yourself that makes you feel uncomfortable.
Risk assessment 2: Specifics of patient risk assessment

It is important to assess patients for risks both to themselves but also to others. During the module you will learn more about risk and how to assess and manage it. The list below gives an overview of the types of risk you should be aware of:

- **Risk to self**
  - Self harm
  - Suicide
  - Self neglect
  - Accidental injury
  - Accidental overdose
- **Risk to others**
  - Violence
  - Abuse: emotional, physical, sexual
  - Other criminal activity
- **Risk from others**
  - Some patients are vulnerable due to their physical or mental state to being exploited or victimised by others. This can include:
    - Financial exploitation
    - Sexual exploitation
    - Violence
    - Theft or other crime
    - Bullying
Asking for help

Within your clinical team you may have considerable experience of managing mental health problems. There may be times however when it is necessary to ask for help from more specialist mental health colleagues or mental health services. This section provides a brief guide to how mental health services are configured in the UK.

The diagram below shows the main elements of mental health services. See below the diagram for further information:

**General hospital mental health services**

Many general hospitals have a ‘liaison psychiatry’ service which will be the first ‘port of call’ for mental health advice for general hospital patients. This will usually consist of a consultant psychiatrist, trainee psychiatrists and specially trained nurses. There may also be counsellors, psychologists and other mental health staff depending on the size of the service. Some services operate around the clock whilst others may only be available during the day. The service will usually assess patients arriving in the accident and emergency department and provide assessment and advice for inpatients on request.
**Inpatient psychiatric services**

Inpatient services are provided by specialist wards in the general hospital or by specialist psychiatric hospitals. They are generally for the most unwell psychiatric patients and often admit patients detained under a section of the Mental Health Act. Inpatient wards usually admit patients based on their address and are divided into general adult (working age) and old age (over 65) services. Many hospitals also offer more specialist units e.g. eating disorders, child and adolescent units, forensic units etc.

Patients can be admitted to an inpatient ward directly from the community, from the general hospital or from other locations e.g. police stations. This will usually be preceded by a psychiatric assessment from a member of the mental health team or several professionals if a patient is to be admitted under the Mental Health Act.

Staff on inpatient psychiatric units are not usually generally medically trained and it is often difficult to manage medically very unwell patients in this environment.

**Community based mental health services**

Community mental health services are provided mainly by generic Community Mental Health Teams (CMHTs) which serve a delimited geographical sector (usually by borough or sector of a borough) and are divided into general adult (working age) and old age (over 65) teams. CMHTs usually consist of a consultant psychiatrist, trainee psychiatrists, specialist nurses, occupational therapists, social workers and psychologists. There are also specialist community teams that tend to serve a wider geographical area and take referrals from the generic teams e.g. memory services, early onset psychosis services or community forensic services. Community drug and alcohol services also operate on a geographical basis.

Patients can be referred to CMHTs by their GP, other medical professionals or other services e.g. social work. Patients may also be able to self refer to these teams.

**Primary care mental health services**

Mental health care is increasingly provided within General Practice, particularly for common mental disorders such as anxiety and depression.

GP practices may have access to psychological services through IAPT (Improved Access to Psychological Therapies) and many practices have counselling services available.
Session summary

Session key points

In this session you have learned about:

- Establishing rapport
- The basics of good interview skills
- Taking a history
- The basics of mental state examination
- Risk assessment
- Communicating with colleagues and asking for help

Session objectives

You should now be able to:

- Recognise why good communication skills are important for assessment of mental health in the general hospital setting
- Recognise the challenges involved in communicating effectively in a busy general hospital setting
- List the key skills required when assessing the mental health of a patient
- Outline the core elements of establishing good rapport with a patient
- Define some key interview skills that are essential to effective assessment of mental health
- Understand the basics of history taking and mental state examination
- Understand the basics of risk assessment and risk management
- Ask for more specialist help appropriately