Psychiatric assessment

What is a psychiatric assessment?

In the consultation, a GP has to make an initial assessment of the nature and severity of the problem and the risk to the individual and other people. The GP then formulates an initial management plan. The patient's concerns need to be taken seriously. Respect and empathy will help to build trust.

For many people presenting with mild psychiatric problems in primary care, it will not be necessary to explore every detail of the full psychiatric assessment outlined below. Often the initial priority is to develop a rapport and demonstrate a caring, supportive approach which can be further developed in future consultations.

The more experience a GP gains in assisting patients with mental health problems, the easier it will become to pick up on non-verbal clues. As soon as a patient enters the consulting room, observe their degree of personal grooming and hygiene and whether they make eye contact when greeting you. Note whether they are appropriately dressed for the time of year and whether they are accompanied by another person (indicating possible social support) or have come alone.

In more severe presentations of psychiatric illness, the priority is to assess the patient promptly, minimise risk and ensure appropriate access to mental healthcare resources as quickly as is necessary and appropriate.

Psychiatric history[1]

- Identity, including marital status, education, occupation, cultural and, spiritual identity.

- Presenting complaint: determine the patient's priorities. Use open-ended questions but quickly narrow down on the diagnosis and look for supporting evidence. Find out:

    - The nature of the problem.
    - The date of onset and whether the onset was slow or sudden.
    - Why and precisely how the person presented at this time.
    - What precipitated the problem.
    - The severity and its course and effect on work and relationships, as well as physical effects on appetite, sleep and sexual drive.
    - Previous episodes, including dates, treatments and outcomes of similar episodes.
    - The description of the problem will also enable an assessment of the patient's insight into their situation. Some patients may deny the existence of a problem and it may be necessary to obtain a history of the illness from a family member or close friend.

- Personal history: should cover many aspects of the individual's life, from early childhood. It should include:
    - Work history: jobs held, reasons for changing jobs, level of satisfaction with employment and ambitions. Assess what effect the illness will have on their job.
    - Marital history and also relationship history with others (intimate or sexual relationships). Establish whether there is anyone they currently feel able to confide in.
    - Family history: close family, including names, ages and their past and present mental and physical health.
    - Illegal activities/violence: criminal record and any previous episodes of violence or other acts of aggression.
    - Present social situation: establish what support they currently have at home.
    - Premorbid personality: note how the individual would describe his or her personality before becoming unwell. Establish the patient's overall mood or temperament - ie anxious, obsessional, solitary or social. If necessary, include detail on:
        - Character traits.
        - Confidence.
        - Religious and moral beliefs.
        - Ambitions and aspirations.
        - Social relationships with family, friends, workmates.
        - Alcohol and illicit drug misuse (past and present)..
        - Full current drug history (prescribed medications, self-prescribed, or recreational).

Mental state assessment[2]

- See the separate Mini Mental State Examination (MMSE) article and the related Screening for Cognitive Impairment (Cognitive Function Tests) and Screening for Depression in Primary Care articles.

- Appearance and behaviour: general appearance, motor behaviour, presence of any abnormal movements, eye contact and body language.
- Speech: rate, volume, quantity of information; disturbance in language or meaning.
- Mood and affect: mood (eg, depressed, euphoric, suspicious); affect (eg, restricted, flattened, inappropriate).
- Content of thought: delusions, suicidal thoughts, amount of thought and rate of production, continuity of ideas.
- Perception: hallucinations, other perceptual disturbances (derealisation; depersonalisation; heightened/dulled perception).
- Cognition: level of consciousness, memory (immediate, recent, remote), orientation (time, place, person), concentration: serial 7s, abstract thinking.
- Insight: extent of the individual's awareness of the problem.

Assessing suicidal intent

See the separate Suicide Risk Assessment and Threats of Suicide article.

- The risk of self-harm is increased if:
    - The patient is pessimistic or feels hopeless.
    - There is a previous history of self-harm or no social support.
- Ask whether things are so bad at the moment that they have thought about ending their life and whether they think there is a real chance that they would attempt this.
- Establish whether they have made any preparations and plans and whether they have decided how they would end their life.
- Ask what has stopped them from killing themself up to now.

Physical examination and investigations

- To exclude physical (organic) causes for current mental problems.

- Investigations (eg, blood tests for anaemia, B12 deficiency, TFTs or syphilis serology) may be required depending on the presentation.

Further reading

- Mental Health Toolkit; Royal College of General Practitioners, 2017

References

1. Vergare M et al; Psychiatric Evaluation of Adults, Third Edition, 2016
2. Snyderman D, Rovner B; Mental status exam in primary care: a review. Am Fam Physician. 2009 Oct 15;80(8):809-14.

Last updated by: Dr Jo Seale 29/11/2022	
Peer reviewed by: Dr Toni Hazell 29/11/2022	**Next review date:** 28/11/2027