Psychiatric Interview First Kit

Manual for Seminars in Psychiatry for English Speaking International and Czech Students

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Preface

This manual is a tool for English speaking international students of medicine who study in the Czech Republic, providing information on how to interview and assess psychiatric patients in Czech language. It is also designed to be used as a tool for medical students who decide to do an internship at a psychiatric department abroad.

In the first part we focus on the way how a psychiatric assessment is carried out in English speaking countries.

In the second part we focus on a complex psychiatric assessment, using questions from Mini International Neuropsychiatric Interview (M.I.N.I.), Structured Clinical Interview SCID-CV. It also includes questions from practitioners based on their practical experience.

The manual is written for students at Faculty of Medicine in Pilsen, however, we hope that any student of medicine in the Czech Republic will find it useful.

Psychiatric Assessment in English Speaking Countries

This short text summarises how to carry out a standard psychiatric assessment when practicing in English speaking countries. This part should be read in conjunction with the other chapters.

Pre-assessment preparation

Review of the referral and collection of available information:
Patients can be referred to the assessment by their general practitioner, other medical specialists, social services, schools, courts, or other agencies. The psychiatrist should go carefully through the referral to understand the concerns of the referring professional.
Some patients come for their first assessment, however, many patients had been assessed before and there is usually a lot of information available on these patients in paper and (or) electronic notes. The assessor should make himself/herself familiar with the previous assessments, risk assessments, etc.

Start of the assessment

Introduction
The assessor has to introduce himself/herself in an appropriate and friendly manner to the patient and others (patient's relatives, advocates, other professionals) attending the assessment.

Limits of confidentiality
The information provided by the patient during the assessment is confidential, however, the confidentiality has its limits which are set by the local legal framework. The limits are specific for a particular country, nevertheless, if the information provided by the patient can result in a risk to other people, and to children and vulnerable adults in particular (for example, patient discloses that he has thoughts to kill his neighbour and has made a plan how to do it, or patient discloses that he was sexually abused by his father and the father has still access to children) there is usually a duty for the assessor to liaise with relevant agencies, like police or social services. The limits of confidentiality should be explained to the patient before the assessment starts.

Information sharing
The assessor should clarify with the patient if he/she is happy for the outcome of the assessment to be shared with his family members or friends, if they ask for any information related to the assessment.

History taking

Presenting complaint and history of presenting complaint
Circumstances leading to the assessment; patient's current symptoms, including mood symptoms, perceptual abnormalities, delusions, sleep problems, anxiety, appetite, weight loss or weight gain.
History of the current episode, possible psychosocial triggers for the episode, Current risks (suicidal ideation, recent sucidal behaviour and self-harm, risk of aggressive behaviour, self-neglect, etc.).

Family history
Details of parents (age, health, cause of death if deceased).
Number, age, and gender of siblings and children.

History of mental illness, suicide, alcoholism and drug dependence in the family.

Personal history
Circumstances of birth.
Postnatal development and developmental milestones.
Schooling (academic achievements, behavioural problems, relationships with schoolmates and staff, qualifications obtained).
Any history of bullying or abuse.
Employment history.
Relationship history – current relationship(s), if sexually active, any history of sexually transmitted disease (STD).
Hobbies.

Social circumstances
Housing (if flat or house, how many bedrooms, if privately owned or provided by a council or a housing association).
Who lives in the household.
Financial circumstances (sources of income, social benefits, debts).

Alcohol and illicit drug use
Alcohol consumption – how many units a week on average, pattern of driniking (binge drinking etc.), how frequently drunk, difficulties to stop, withdrawal symptoms (sweating, tremor).

Illicit drugs – what drugs and how frequently, in which form, withdrawal symptoms, previous and current treatments for addictions, rehab admissions, etc.

Past medical history
History of any serious physical illness.
Any chronic condition (diabetes, hypthyroidism, high blood pressure, epilepsy, etc.).
Any history of head injury, if unconscious or not.
Smoking status.
Contraception in women.