COMPREHENSIVE PSYCHIATRIC/ PSYCHOSOCIAL ASSESSMENT

Assessment should include:[9,13,18,23,83,87][4]

- identifying data: name, gender, age, ethnicity, marital status, sources of history and reliability of historian/informants
- presenting problem(s): in the person's own words
- history of present illness/episode
- past psychiatric history
- past medical and surgical history
- current medications and recent past medications
- drug allergies/sensitivities
- medical systems review
- substance use history
- forensic history
- whānau/family history
- psychosocial history
- Mental State Examination
- physical examination
- differential diagnosis
- formulation
- working diagnosis
- treatment plan.

PRESENTING PROBLEM(S)

Allow the person to describe in their own words their view of their problem. This will aid the establishing of rapport and avoid potential misattribution.

Seek input from the person's whānau/family/support people if appropriate. Invite them to give a description of their concerns about the person or any changes that they have noticed.

HISTORY OF PRESENT ILLNESS

It is important to obtain an account of the emergence, duration and severity of all symptoms, as well as any precipitating or aggravating factors, such as worsening of mood symptoms in relation to alcohol or substance use. As illnesses such as depression are highly associated with suicidality and suicidal attempts, one needs to be alert to symptoms of lowered mood, anhedonia, sadness, tearfulness, irritability and hopelessness. The latter is a frequent indicator of increased risk of suicide. Sleep and appetite changes such as early morning wakening, weight loss, psychomotor agitation and retardation, are all important indicators of underlying depression.[83]

Elevated mood, elation, grandiosity, a decreased need for sleep, disinhibition, or unstable mood, may indicate the presence of a manic phase of a bipolar mood disorder. Bipolar disorders are associated with increased risk. Mixed mood states may also exist.

A history of violence or impulsivity is important as violent males, in particular, may be at increased risk, especially if depressed or intoxicated.

Anxiety disorders may also be present and may co-exist with depression. Panic attacks may cause distress and lead to suicide attempts. There is an increased risk of suicide in association with anxiety disorders and following serious trauma, such as physical or sexual abuse.

Psychotic illness may be indicated by the presence of symptoms such as delusions and hallucinations. These may be found in association with schizophrenia, manic depressive psychosis, psychotic depression and drug induced psychoses. Nihilistic delusions and delusions of guilt and sin in depressed people may engender feelings of hopelessness and lead to suicide.

Auditory command hallucinations and delusions of control may considerably increase suicide risk in a person with psychosis, particularly if the person is unable to resist these. Suicide is not just a risk when the person is acutely unwell, but may also occur after the acute phase, when the person develops insight and becomes aware of the nature and seriousness of their illness. It can also follow the demoralisation that may accompany years of chronic illness.

People with histories of disturbed interpersonal relations and personality disorder, may have made repeated attempts at deliberate self-harm and suicide. They also have an elevated risk of suicide over time.

PAST PSYCHIATRIC HISTORY

It is important to establish the history of past illness and its course, dates and duration of episodes of illness, as well as the names of hospitals and the nature of any treatment. Periods of treatment by a general practitioner should also be noted. Often the person will know the diagnosis but if not, their recall of symptoms will be helpful. Episodes should be noted in chronological order, as well as any unusual circumstances in which the illness appeared to develop. Hospital records should always be requested. Details of all past suicidal behaviour, its seriousness and outcome should be recorded.

PAST MEDICAL/SURGICAL HISTORY

Note any serious illnesses, operations or accidents, with their dates of onset, the duration and nature. Some physical illnesses and their treatment may have psychiatric sequelae. For instance, organic brain syndrome resulting from a motor vehicle accident may cause aggression and impulsivity. Endocrine disorders such as hypothyroidism may be associated with depression. Cerebral tumours and neurological conditions may have behavioural components. People with chronic neurological disorders such as epilepsy, may be at increased risk of developing a psychiatric disorder. Chronic physical conditions such as HIV/AIDS, may lead to hopelessness and depression.

CURRENT AND RECENT PAST MEDICATION

Steroids may affect mood and discontinuation may precipitate depression. Hypotensive agents and oral contraceptives may contribute to the development of depression. Stimulants may also cause mood changes and occasionally paranoid states. Anti-Parkinsonian drugs and hypnotics may cause confusional states, particularly in the elderly.

DRUG ALLERGIES/SENSITIVITIES

It is important to establish drug allergies or sensitivities before initiating any treatments.

SUBSTANCE USE HISTORY

Because of the frequent co-morbidity of substance use disorders with psychiatric disorder and their association with suicide attempts because of disinhibition, or mood changes, associated with withdrawal syndromes, it is vital to screen for these disorders.

It is important to obtain a history of all substance use (eg, alcohol, marijuana, stimulants, hallucinogens, opiates, inhalants etc), screening for indicators of abuse or dependency. One should ascertain current and past use, periods of heaviest use and note any increase in risk-taking behaviours associated with drug use. It may be useful to consult other informants on this topic as people often under-report their substance use.

FORENSIC HISTORY

It is important to establish any history of antisocial behaviour or offending. This may reveal a past history of violent offending and impulsivity, or may indicate the presence of an antisocial personality disorder. This is important to establish because of the association between impulsivity and antisocial behaviour in males, and suicide. Previous use of firearms or other weapons may indicate further serious risk of harm to self or others. There may be links between alcohol or drug taking and impending court proceedings, which may be a significant contributing factor.

WHĀNAU/FAMILY HISTORY

A positive whānau/family history of psychiatric disorder, particularly mood disorder, would indicate possible genetic vulnerability. A whānau/family history of suicide or suicidal behaviour is a significant risk factor. Loss of a parent at an early age may contribute to the later development of depression, particularly in females. Any whānau/family history of violence or drug use may also be relevant.

PSYCHOSOCIAL HISTORY

A psychosocial history should cover the person's birth and early development, a clear history of their childhood years to include any significant adverse circumstances such as disrupted attachment, physical or sexual abuse, periods in care, etc. School history should be taken to establish the presence of any learning disability or academic problems and particularly any indiscipline or truancy.

The person's occupational history should be recorded, any significant periods of unemployment, redundancy, skills, qualifications, level of employment and functioning in job, and the presence of any work difficulties.

The person's relationship history, including their ability to form and sustain relationships over time, is important and the interviewer should note any persisting or recurring conflicts or relationship difficulties. If the person is in a relationship currently it should be noted whether this is a happy and supportive, or a conflictual relationship.

Understanding the person's current situation is important. There should be an attempt to elucidate the person's support network, any friends, interests outside of work, preferred activities, overall satisfaction with life, present stressors, and previous episodes of deliberate self-harm.

DIFFERENTIAL DIAGNOSIS

A list of all relevant possible diagnoses should be made, at least with reference to the first three Axes of DSM IV-TR.[83]

FORMULATION

The formulation synthesises the above information, drawing together an explanation of why this 'particular person has presented in this particular way at this particular time'. A formulation demonstrates a clinician's understanding of factors that predisposed the person to becoming suicidal (eg, a whānau/family and personal history of depression) and factors that precipitated their present distress (eg, grief over a relationship break up). Factors that perpetuate the person's despair are described (eg, depressive cognitions that they are 'useless') and also any protective factors, both internal (eg, intelligent, insightful) and external (eg, good and helpful social supports). The formulation should put into context the current illness in terms of their past history and social circumstances. This individual's understanding complements a specific working diagnosis or diagnoses, allowing a clear management plan to be developed for the given individual to meet their needs.