1 Psychiatric assessment in community practice

Peter Yellowlees

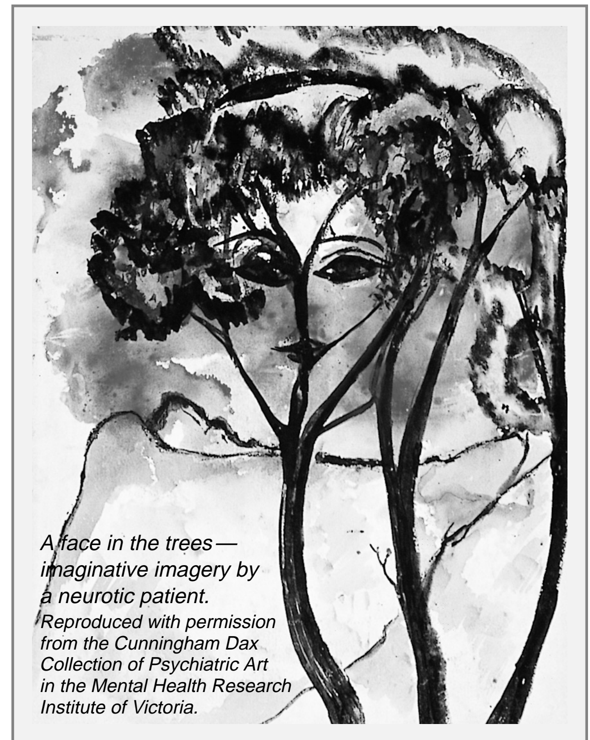
There are advantages in meeting patients on their home ground

Psychiatric assessments must often be performed in the community, which may mean in the community health clinic or general practice surgery, the local supermarket, bank, motel or the patient's own home. A large number of assessments are done by telephone, particularly in rural areas where patients are unable to get in to see their general practitioner, or through the Royal Flying Doctor Service. Emergency assessments may take place in a police station, hospital emergency department, boarding house, hostel, or at the doctor's own home when someone turns up inappropriately or unannounced. More dramatic assessments may be done in sieges or after major traumas such as motor vehicle accidents, homicides or suicides. A process for emergency assessments is described in Box 1.

Little has been written about the "real world" of psychiatric assessment in community practice, with no references on this topic appearing on Medline or Psychlit from 1983 to 1996. Major psychiatric textbooks[1-3] give detailed descriptions of how to examine the mental state of patients, as do textbooks on general practice.[4] Such an assessment is all that one can make when seeing a patient in a controlled office or clinic setting, and the descriptions in the literature of how to do mental state examinations are generally written from that perspective. This article concentrates on psychiatric assessments as made by general practitioners and uses the mental state assessment as only one of a range of data-gathering exercises that are often required in community settings.

One important issue in community practice is the focus of the psychiatric presentation, because this is what gives the assessment its purpose. It is crucial to be pragmatic and to clarify what are the patient's major concerns before addressing any of one's own. This frequently means that considerable time is spent on issues such as finance, food, housing and carers' needs, which often need instant action.[5] In community settings exploration of psychopathology and symptomatic treatment strategies is often of less immediate importance and can usually be more easily addressed later, once the trust of the patient has been engaged.

In emergency situations, assessments may often be fairly brief, especially if a situation is out of control. Such assessments should generally be aimed at answering the simple questions that differentiate whether a patient is psychiatrically unwell, physically unwell or has a personality disorder. Obviously, any combination of these can occur; Box 2 shows a decision tree using these broad categorisations.



A face in the trees — imaginative imagery by a neurotic patient.
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Synopsis

- When undertaking a psychiatric assessment in the community, success depends on engaging with the patient's major concerns first, winning trust and laying the foundation for more formal assessment of diagnosis and treatment later.
- The setting within the community may provide additional data that are valuable in the assessment (e.g., evidence of the patient's living skills and social connections).
- For effective assessment and follow-up, it is important to work with other services and mental health professionals, such as community mental health care teams.
- Some assessments in the community can be stressful or even dangerous; clinicians should take steps to look after themselves during and after stressful situations.

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1 Emergency psychiatric assessment in the community

If called to undertake an emergency psychiatric assessment consider the following:

Before the interview

1. Attempt to predict the range of outcomes before attending
   - Rapidly collect all available information
   - Discuss with colleagues or other doctors who know the patient if possible.
2. Plan for the outcomes
   - Check availability of patient's family, police and other health professionals such as community mental health team members
   - Do not go out alone if the situation sounds dangerous
   - Ensure appropriate medications, certification documents and a mobile phone are accessible
   - Check availability of a hospital bed, or availability of family or case managers to spend more time with the patient if admission to hospital can be avoided
   - If hospitalisation is a likely outcome, plan the means of transport for the patient, in advance if possible.

During the interview

- Introduce yourself and explain why you are present
- Remain courteous and non-threatening, but be honest and direct
- Avoid confrontation at all costs — be prepared to "agree to differ" with the patient's perspective and to address what they see as the major issues first
- Do not attempt to manhandle the patient, except to prevent serious assault or suicide attempts
- Explain to the patient what is the agreed plan of action.

After the interview

- Write comprehensive case notes as soon as possible
- Check yourself for your personal responses to the incident to ensure that you are not adversely affected
- If the incident was traumatic, or you feel anxious or distressed, discuss these issues with a colleague or friend, or use a more formal debriefing process.

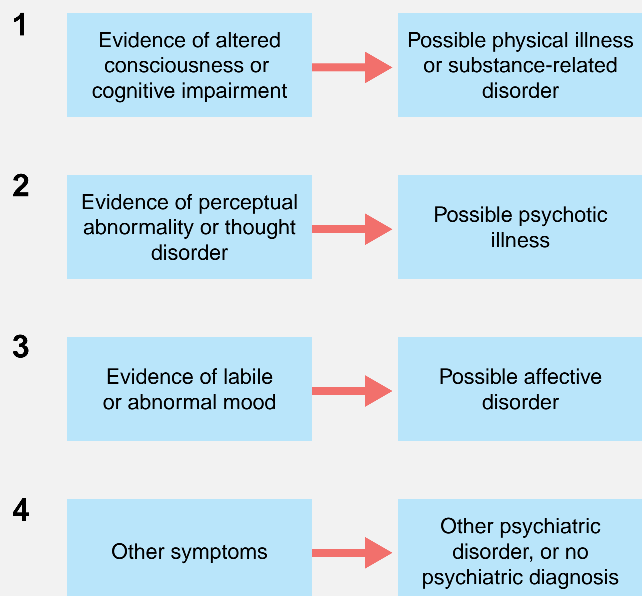
Types of assessments

Face-to-face mental state assessment of an individual

The formal mental state examination is the psychiatric equivalent of a blood pressure evaluation: like blood pressure, an individual's mental state varies significantly over time and in different settings. All doctors who see patients should be able to perform mental state examinations, even if these are somewhat cursory on occasions, and certainly all general practitioners should be able to perform such assessments to a high and reliable standard.

Various approaches to mental state assessments and other structured diagnostic assessments[6-8] are documented in the literature. Structured diagnostic assessments differ from mental state assessments by taking into account other historical and background information with the aim of formulating a diagnosis, rather than simply describing an individual's mental state. The mental state is a vital part of any diagnostic process and should be noted separately from the results of a structured diagnostic assessment. Box 3 describes a simple form of mental state assessment that I use in my own practice. There are only 10 headings to remember and these can easily be kept in the front of the diary, or on a card on the desk, to aid recall if necessary. Brief cognitive assessments[3] are also invaluable tools if there is concern about dementia, delirium or other cognitive impairment. The most commonly used brief instrument for such targeted assessments is the "mini mental state examination",[8] which takes less than five minutes to complete. Experienced clinicians will not, of course, use all aspects of these assessments at all times.

2 Decision tree for brief emergency assessments



Mental state of others

Details of how to do a family assessment are beyond the scope of this article, but are well covered in the literature.[9,10] It is crucial to be able to interview and assess other family members or the patient's friends or acquaintances. While this is mostly part of a data-gathering exercise about the patient, there are occasions (such as when a patient's delusional belief is supported by relatives) when a more careful mental state assessment of a specific relative is indicated. Families of patients present in many different ways, but are frequently laden with guilt, exhausted or angry. Their response to these emotions is sometimes to blame the clinician for not adequately helping or curing their family member immediately. Clinicians must be aware of these potential tensions, which can do significant harm to the doctor–patient relationship.

Assessment of the home or clinical setting

Patients' homes can provide much information about their mental state and their psychiatric disorder. I have seen instances of homes with very high fences, "to keep out the rays", as well as others with covered up videos and unplugged televisions and radios, to stop "the bugging". It is often rewarding to see which magazines or books patients have been reading, and whether they have added their own comments. The general state of repair of the house is an important factor. It is interesting to observe how people deal with incoming mail, whether this is still in the letterbox or spread widely around the house in a disorganised way, or to see whether the house is overmeticulously clean and neat. I can well recall one patient with an obsessive–compulsive disorder who followed me everywhere I went in the house with a brush and broom.

Kitchens and backyards are of particular importance. If possible it is always worthwhile looking inside a fridge, with the patient's consent, of course. This is generally given as most people are happy to show you around, and pleased at your genuine concern and interest in their welfare. Some patients are impoverished, or spend their money on large amounts of cigarettes and alcohol. This is not necessarily obvious until the fridge and bins are checked. In the case of elderly patients a review of the kitchen can rapidly indicate whether they are really able to look after themselves independently. If there is some question of dementia then it is crucial to make sure that there is electricity rather than gas in the house, and that kettles have not been burned through by being left on the stove for extensive periods of time.

During a home visit I generally try to go for a wander in the backyard, not only to get an idea of the patient's interests and activities, but also to look for empty beer bottles that might suggest that the patient's idea of "social" drinking is rather different from my own.

There are, of course, some home visits that are memorable. I have seen homes that were almost impossible to enter because of the piles of rubbish accumulated over decades. In other homes there has been no power or running water, while in some places animals seem to have taken priority over the human inhabitants. Some assessments have been made easier because patients have scribbled their psychotic ideas, in the form of graffiti, on walls either inside or outside the house. Almost every home visit substantially improves my understanding of the patient.

3 Individual mental state assessment

***A**ppearance*

Simply describe the patient's physical presentation: clothing, hygiene and cultural appropriateness.

***B**ehaviour*

Briefly describe the patient's behavioural style, including agitation, retardation, and any inappropriate or unusual behaviour.

***C**onversation*

Describe both the content of conversation, perhaps with some quotes, as well as the form, which includes the rate of conversation, as well as the logic, or otherwise, of thought processes.

***A**ffect and mood*

Note the individual's mood level, variability, range, intensity and appropriateness.

***P**erceptual abnormalities*

Note any psychotic symptoms, or other perceptual abnormalities, including hallucinations and delusions. These perceptual abnormalities can occur in any of the five senses.

***C**ognition*

Describe orientation, memory and attention, or ability to concentrate. The Mini Mental State Examination[8] is an excellent brief cognitive assessment that can be performed by most clinicians in three to five minute.

***D**angerousness*

Comment on any suicidal or homicidal ideas, beliefs or feelings.

***I**nsight*

Assess the patient's insight into his or her condition. This may be hard to judge, but is particularly important because of the management implications of poor treatment compliance.

***J**udgement*

Assess the patient's level of judgement, in particular regarding safety issues.

***R**apport*

Briefly comment on how you believe the interaction was between yourself and the patient, and in particular how the patient made you feel.

Telephone assessments

The long phone call from a patient who is emotionally distressed always seems to occur either in the middle of a busy clinic, or late on a Friday afternoon when you are about to leave for a few well-earned days away. Most patients will understand that you are unable to speak to them at length at that time but that you will see or phone them later.

When assessing patients by telephone it is invaluable to discuss their mental state, and therefore potentially their diagnosis and management, with someone else in the house if this is possible, and if the patient consents. This may provide more information on the patient's mental state than the patient will give over the telephone, and is particularly helpful in assessing safety and dangerousness issues. Teleconferences between a psychiatrist, patient and community mental health team members and/or general practitioners may be helpful for patients living in remote areas.

Videoconferencing, as a relatively new communications technology, is becoming increasingly popular in Australia, and there are now several articles describing the process of psychiatric interviews on telemedicine videoconferencing systems.[11,12]

Assessment teams and procedures

In recent years there has been increasing development of "shared care" programs[13-15] to provide treatment services for the large number of patients with psychiatric disorders who present to general practitioners.[16] These schemes generally involve a psychiatrist working closely with a general practice to consult and liaise with the general practitioner in the management of patients. The general practitioner continues to hold the control role of providing long term treatment for all conditions affecting the patient, but is assisted by case managers (such as community psychiatric nurses) and advice and specialist consultation from psychiatrists.

Over the past 30 years, mental health care has been gradually deinstitutionalised. The National Mental Health Plan[17] supports a move to community-based treatment programs, with the development of multidisciplinary community mental health care teams based in local clinics. Home visits in psychiatric practice now have key clinical importance. Most community mental health teams have a protocol and policy in place for home visits, although admittedly these tend to be mainly for ensuring staff safety rather than looking at the assessment and home visit process itself. The issues of main significance in performing home visits for psychiatric assessments are as follows:

Control: At home the patient has much more control than in the normal clinical interview setting in a health facility. Clinicians can only be invited in (except in certain legally defined circumstances) and can equally easily be asked to leave. It is the patient who is on familiar territory rather than the clinician, and, while the patient may be anxious regarding the visit and assessment, the same applies to the clinician. The latter does not have all the usual clinical trappings, not only of authority and power, but also of access to secretarial staff, telephones, privacy, patient information kits, medications, and perhaps escape routes.

Sociocultural issues: An amazing amount can be learned on a home visit regarding a patient's sociocultural background, class, activities and interests. Most patients, if they know you are

coming, will try and make you feel comfortable. I personally tend to find that sitting around the kitchen table with a cup of tea is usually both more appropriate, and more comfortable, than using the lounge room, which is often offered out of politeness. Patients are generally pleased to see you at their home, and often comment, in later interviews, that they really know that you know how they live, and that it was good that you had taken the trouble to come and see them rather than the other way around. I believe that home assessments should be performed much more frequently than they are at present, especially in relation to patients who need to be hospitalised, an expensive process that can often be shortened by a better understanding of the patient's home situation.

Safety issues: Home visits may be dangerous, particularly if the clinician has been asked to certify a patient, is uninvited, or is seeing a patient who feels very threatened. If there is any suggestion that the home visit is likely to be dangerous then it is essential to be accompanied. Community mental health teams are starting to work more closely with general practitioners, so that a team member may assist general practitioners in this situation.

If it is necessary to do a home visit that is likely to be dangerous then it should be performed with an appropriate number of police officers. There is nothing clever about losing control of a situation when the patient is likely to need admission to hospital against his or her will. Planning beforehand is essential, as it is the police who are the experts at immobilising people, not clinicians.

A mobile phone is necessary for any home visit, to allow the clinician to organise a bed for the patient immediately, contact relatives, or speak to other clinicians. This allows decisions to be made and implemented during the home visit itself, which is particularly important if the patient is overtly unwell and needs immediate assistance.

Process: There are some obvious points that will help make a home visit successful. It is essential to allow adequate time for the visit, properly introduce yourself and explain why you are there. An identification card may be required as proof of identity. It is important to have a quiet environment in which to interview the patient and family, bearing in mind that you may wish to see the patient alone as well. This means asking for the television to be turned off, for noisy animals to be removed and, if necessary, for children to be controlled, or looked after in another room. None of these are necessarily straightforward requests in some households. Essential small talk is much easier on patients' home ground, and much can be learned about the patient's functional capacity and ability by asking about, for instance, trophies on the walls, or how they look after their pets. Frequently, offers of drinks, cakes, cups of tea and the like are made, and I generally accept these, except in some instances when it is obvious that the process of making a cup of tea is going to take a long time and interfere with the interview process, or when a serious lack of hygiene is evident. Ethical issues of confidentiality and privacy are vital and must be considered. This is particularly important when talking to family members, neighbours, police and any other people who might be involved with the patient.

Case history 1: Going to the patient

The local social services reported that an unkempt, dirty and bedraggled woman had taken to sleeping in a local park. She appeared to be physically unwell, with a bad cough and severe sunburn, and was scavenging food from bins. She appeared frightened when approached and was refusing assistance. Several complaints about her presence had been made by a child care centre next to the park.

Background information

A variety of health services were contacted and it appeared that the woman had been diagnosed five years previously with paranoid schizophrenia, came from interstate and had taken to travelling around the country as an itinerant person. She had a background history of severe trauma and abuse, was non-compliant with treatment and consistently absconded from hospitals if admitted involuntarily.

Engagement

A female community nurse and I did a brief initial assessment of the woman in the park. She was interviewed from about 10 metres away, which was as close as she would allow, and food, soap and towels, a small amount of money and a warm blanket were left with her. She appeared frightened and thought disordered, seemed to have a chronic chest infection and was underweight. She agreed to the nurse visiting her on a regular basis to provide food. The social services were informed of this arrangement, and over the next fortnight she was seen on most days. A general practitioner who knew her from the past visited her in the park with the nurse and she allowed him to examine her chest in the park toilets with the nurse assisting. She was prescribed antibiotics and eventually agreed to a one week hospital admission on a voluntary basis.

Further assessment

In hospital she was washed, and attended by a podiatrist and a hairdresser. With nursing care and regular food her health improved, and this (plus her voluntary status) increased her trust in the various clinicians. Back pay of her pension was organised and she agreed to take low doses of antipsychotics orally. Great care was taken not to repeat the dynamics of abuse and external control by allowing her to make her own choices and by concentrating on the areas of need that she saw as important initially.

Follow-up

Temporary accommodation was arranged after her brief hospitalisation and she was visited at her new home by her case manager (a nurse), either alone or with me or her general practitioner. She continued taking oral antipsychotics and when she decided, after three months, to return to her home State she allowed us to help with her travel arrangements and to arrange appropriate psychiatric follow-up.

Case history 2: A team approach

A 45-year-old woman with a 20-year history of a poorly controlled bipolar disorder had been seeing her general practitioner irregularly and now presented to him in a manic state. She had grandiose delusions, was overspending and was constantly harassing the local radio station because she wanted to be allowed to go on air to inform everyone that she was saving the world.

The general practitioner knew her and her family well, and, after a home visit, was able to ascertain that her parents were coping with her and that there was no immediate apparent physical danger to either her or her family.

Management

The general practitioner consulted me, and I assessed the patient and her family at home with him.

A management plan was drawn up in conjunction with the patient and a case manager from the community mental health team. A copy of the plan, signed by all parties including the patient and her parents, was given to the patient. This plan addressed a series of social and psychological needs, as well as the need for regular medication which was to be monitored by a case manager. The plan also stated that if any of the parties to the plan, including the patient, felt that the patient was becoming more unwell then they could ask for a further psychiatric assessment from me, and that the patient would comply with any management changes as a consequence of that assessment.

Further assessment

I undertook two more home assessments in the next three months, one at the request of the general practitioner and one at the request of the patient. One other assessment was performed by videoconferencing as I had moved interstate.

The patient's wishes to remain at home were upheld and the team approach, with the general practitioner and case manager working with the patient and her family, with me acting as a consultant psychiatrist for the whole group, worked successfully.

Follow-up

Over the course of three months the patient's symptoms subsided, she maintained a part-time voluntary job, greatly strengthened her relationship with her general practitioner, and agreed to regular and consistent follow-up and monitoring of her illness by him in future.

Other community settings

Often the most public places are the safest places to meet patients if you consider safety to be a major issue. Very few patients will be aggressive in a coffee shop, a park or in the street. If I am really concerned about a patient being dangerous I will often go for a walk with them in a very public place, and talk while we are walking. This not only makes me, and generally the patient, feel more at ease, but it also gives me an idea of the patient's mental state as we walk in a normal public environment. Patients who are psychotic and hallucinating often comment on their symptoms when walking, but would not necessarily have done so in a clinic interview room where there is less external stimulation.

Self-care for the clinician

There is no doubt that dealing with patients who have an acute psychiatric illness can be stressful, particularly for clinicians working in the community who are isolated or find immediate advice difficult to obtain.

If the presentation has been frightening or traumatic, then it is important to allow yourself to "debrief". This may simply range from having a cup of coffee and a few minutes' time out, to making sure that you are included in a full debriefing process with appropriate professional support. Most of the time it is sufficient to talk to trusted colleagues and to monitor yourself — but it is important to do this talking, and not to deny the emotional impact of dealing with difficult situations. In the event of significant continuing stress, or after a major traumatic event, doctors are just as likely as other health care professionals or members of the community to develop anxiety, depression or post-traumatic stress disorders. It is crucial that these are treated appropriately and that colleagues are consulted for advice.

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