

THE EMERGENCY PSYCHIATRIC ASSESSMENT

INTRODUCTION

1. Compared with a typical psychiatric interview, the psychiatric assessment conducted in the Emergency Department is usually shorter and frequently less private.

The Primary goal of the assessment is to:

- Diagnostic Assessment
- Address patient and general public safety/risk issues
- Determine appropriate patient disposition post-discharge from ED

The assessment is usually complicated by the fact that the patient may be unwilling and uncooperative with the interview process; their mental state being affected by substance abuse.

Collecting collateral history from past notes - safety/risk issues and past diagnosis and treatment response, and from multiple informants is essential to the assessment process in order to come to a diagnostic understanding as to why this patient has presented to ED.

The interview should not be formulaic, but flexible tailored to develop rapport as important sensitive information will need to be elicited; often in a brief time frame to make a diagnosis. The interview will need to be adapted to the patients' needs and personality style.

2. In assessing the patient the clinician should firstly establish, whenever possible:

- Modem of referral to ED
- Reason the patient gives for coming to ED
- Basic demographic information
- Patients behaviour prior to presentation
- Reads past notes
- Identify any risk issues

The purpose of the psychiatric assessment is to come to a diagnostic understanding of the patient "WHY DID THIS PATIENT PRESENT AT THIS TIME IN THIS WAY"; such assessment drives the management plan for the patient.

COMPONENTS OF THE INTERVIEW

1. **Patient Identification**
 - Who is the patient and how they got to the ED
 - Demographic information
2. **Patients Chief Complaint**
 - What the patient sees as their presenting problem (their own words)

3. **History of Presenting Complaint**

- Establish chronology of symptom development from when they were last well to currently.
- Enquire into symptoms cluster to establish a syndrome plus establish negative lines of enquiry e.g. not hearing voices etc....
- Conducts a risk assessment
- Establish stressors (biological, psychosocial, social) that may have contributed to the development of their symptoms.
- If drugs or alcohol are etiologically related to the patients' presentation then record their drug and alcohol history here.
- It is important to develop your own probe questions to elicit depressive, anxiety psychotic etc. symptoms.

4. **Past Psychiatric History**

- Prior hospitalisation and treatment response/failures
- Last hospitalisation
- Prior suicide/DSH attempts

5. **Substance Abuse History**

6. **Medical History**

- Hx of DM, epilepsy, H1 hepatitis, HIV, etc.
- Medication and allergy

7. **Personal & Social History**

- Instead of taking a detailed developmental history, rather focus on the patients social circumstances (living situation, financial support, employment history, social supports, forensic history and legal status etc.
- Document your understanding of the patients' personality structure.

MENTAL STATE EXAMINATION

- Introduction
- Speech - ? thought disorder, themes of speech etc.
- Mood/affect – their emotional and disposition, your assessment to their disposition.
- Risk assessment
- Abnormal beliefs/perception
- Cognitive assessment – MMSE, MOCA
- Insight

MANAGEMENT PLAN

1. Summarise your understanding of the case and the patient's diagnostic and differential diagnosis. Generate the patient's problem list that needs to be addressed to get them well.

2. To address the problem list; I list the actions under the following headings.

- Acute
- Short Term
- Long Term

If you are going to discharge the patient think of:

- Medication Psychological treatments
- Community resources/referral
- Risk to patient, family and children that need to be addressed
- Write down a plan.