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Psychiatric Interview and Mental State Examination

Practical 01 / Communication role-play

Aim

Conduct a brief psychiatric interview and document the mental state in descriptive language.

Principle

The history records the person's experience over time. The mental state examination describes findings observed or elicited during the current encounter.

Materials and Requirements

- Role-play case, quiet room and mental state record
- Relevant collateral history when available and consented

Procedure

1. Introduce yourself, establish privacy and ask the person how they would like to start. Explain limits of confidentiality when safety is at risk.
2. Confirm identity, preferred language and comfort, reduce distractions and explain the student role. Ask what the person most wants to discuss and what support would help.
3. Explore the main concern, onset, function, sleep, medicines, medical illness and substance use. Ask about relevant past and family history.
4. Establish the person's baseline, current change and effect on work, study, relationships and self-care. Record time course and context and indicate whether details came from the person or an agreed collateral source.

Continue with step 5 on the next page.

Procedure Continued

Psychiatric Interview and Mental State Examination

5. Record appearance, behaviour, speech, reported mood and observed affect. Explore thought form and content, perception and cognitive orientation.
6. Record what was observed and what was reported separately. Describe speech rate, affect range and thought organisation in neutral language and check attention or orientation using an accessible task.
7. Assess insight and judgement as appropriate. Ask sensitively about immediate safety, including self-harm concerns.
8. Ask about immediate safety and understanding of the current difficulties in direct, non-judgemental terms. Explain what will happen if a concern needs urgent team support.
9. Present a short, neutral account including strengths, uncertainties and next assessment needs.
10. Present a brief account of symptoms, current mental state, strengths and immediate needs. Name the supervising assessor and note any part that was incomplete or limited by communication.

Precautions

- Use specific observations instead of labels or judgemental terms.
- Obtain consent for routine collateral history and follow the safety policy for immediate risk.

Observations and Interpretation

Psychiatric Interview and Mental State Examination

Observations and Record

Item	What to record	What it tells you
Speech and behaviour	Rate, volume, cooperation and motor activity	Captures observable features
Mood and thoughts	Subjective mood, affect, form and content	Describes distress and symptom pattern
Cognition and safety	Attention, orientation, insight and immediate concerns	Determines needs and urgency

Worked Example

A person describes sleeping two hours nightly without tiredness. Speech is rapid, difficult to interrupt and shifts topics. A relative reports uncharacteristic spending.

Result and Interpretation

Document the observed and reported features. Consider a manic syndrome while reviewing substances, medicines, medical causes and safety.

Viva Questions and Answers

What distinguishes mood from affect?

Mood is the person's reported emotional state. Affect is the observed expression.

Why check medicines and substances?

Their effects can contribute to psychiatric symptoms or mimic a primary disorder.

Depression and Suicide Risk Assessment

Practical 02 / Communication role-play

Aim

Assess depressive symptoms and current safety and hand over urgent findings respectfully.

Principle

Symptoms, duration, impairment and differential diagnosis inform assessment of depression. Safety evaluation considers current thoughts, intent, recent behaviour, access to support and ability to stay safe.

Materials and Requirements

- Standardised patient case, private room and local crisis pathway
- Documentation and handover card

Procedure

1. Ask permission to discuss mood, loss of interest, energy, sleep, appetite and functioning. Establish onset, duration and severity.
2. Establish privacy, permission and preferred language, then invite the person to describe changes in mood, interest and daily functioning. Clarify the timeline and severity in their own words.
3. Ask about past episodes including elevated mood, medicines, substance use, medical contributors and available support.
4. Review previous episodes, treatment, past elevated mood, use of substances and medical events. Ask who the person can contact for help and what has helped them feel safer.
5. Ask directly about current thoughts of self-harm or suicide, intention to act and recent behaviour. Clarify immediate danger and willingness to accept support.

Continue with step 6 on the next page.

Procedure Continued

Depression and Suicide Risk Assessment

6. Ask clearly about current thoughts, intent and ability to remain safe. Confirm the immediate setting and available support and give the supervisor a clear description of urgent concerns.
7. If immediate safety is uncertain, alert the supervisor and arrange for appropriate staff to stay with the patient while the urgent pathway is activated.
8. Keep appropriate staff with the person while arranging urgent assessment if safety is uncertain. Use the role-play to rehearse who receives the call and what information is necessary to convey.
9. Discuss a clinician-led assessment, supports and follow-up. Record the person's stated concerns and who will take responsibility for the next step.
10. Agree on the clinical handover and safe contact or follow-up plan. Record the time and receiving team, relevant stated concerns and who will assume responsibility.

Precautions

• Avoid numerical labels as a substitute for an individual assessment.

• Obtain urgent supervision when safety is unclear and keep the conversation private.

Observations and Interpretation

Depression and Suicide Risk Assessment

Observations and Record

Item	What to record	What it tells you
Mood and function	Symptoms, duration and impact on daily life	Supports clinical assessment
Safety	Current intention, recent behaviour and support	Identifies immediate needs
Plan	Named responsibility, timing and documented handover	Supports continuity and supervision

Worked Example

A distressed patient reports current intent, feels unable to remain safe and has no support nearby. The student calls the supervisor and stays engaged while staff arrange immediate care.

Result and Interpretation

Use the urgent safety pathway and provide a direct handover. A score alone cannot determine safety or disposition.

Viva Questions and Answers

Why ask directly about suicidal thoughts?

It lets the person share the safety concern and helps guide immediate care.

What deserves special attention before attributing symptoms to unipolar depression?

Past episodes of elevated mood or markedly reduced need for sleep.

Psychosis Delirium and Collateral History

Practical 03 / Clinical or documentation case

Aim

Distinguish features that suggest a primary psychiatric presentation from a possible acute medical cause.

Principle

Acute change with fluctuating attention and awareness raises concern for delirium. Perceptual or belief changes may occur with several medical, substance-related and psychiatric conditions.

Materials and Requirements

- Two fictional interview transcripts, observation trend and medication list
- Brief attention task and collateral history prompt

Procedure

1. Check immediate safety, vital signs and a focused symptom timeline. Establish baseline cognition and function.
2. Identify vital observations, self-care or safety concerns and baseline function. Ask a permitted collateral source when the change first appeared and whether symptoms vary across the day.
3. Assess attention and orientation using an accessible clinical task. Observe fluctuation and level of alertness.
4. Use a short attention task suited to language and hearing and check alertness more than once if feasible. Record actual performance and testing limits.
5. Ask about perception, beliefs and thought organisation using neutral questions. Review medicines, recent illness and substance exposure.

Continue with step 6 on the next page.

Procedure Continued

Psychosis Delirium and Collateral History

6. Ask what experiences are most distressing without confirming or challenging beliefs. Describe speech, reported perception and any disorganisation, then check medication and acute illness timing.
7. Obtain appropriate collateral history and compare changes over hours or days with changes over weeks or months.
8. Compare the patient account, observation chart and collateral timeline. Note any abrupt deviation from baseline, fluctuation or plausible physical trigger that changes the urgency.
9. State what requires urgent medical investigation and how you would support the patient's understanding.
10. Give the key findings and why immediate medical review is needed in the acute case. Communicate understandable next steps and document the receiving clinician.

Precautions

- Check sensory or language needs before interpreting attention tasks.
- Avoid confrontation about distressing beliefs or perceptions.

Observations and Interpretation

Psychosis Delirium and Collateral History

Observations and Record

Item	What to record	What it tells you
Time course	Baseline and fluctuations	Supports differentiation
Attention and alertness	Test performance and observed changes	Flags possible delirium
Context	Vital signs, drugs and medical symptoms	Suggests reversible causes to assess

Worked Example

An older patient has new visual experiences after acute illness. Attention is poor and alertness fluctuates over a shift, unlike the baseline reported by family.

Result and Interpretation

These features raise concern for delirium and require prompt medical review and a search for underlying causes.

Viva Questions and Answers

Which feature particularly supports delirium?

An acute, fluctuating disturbance of attention and awareness.

Why seek collateral history?

It helps establish baseline and objectively dates the change.

Substance Use Assessment and Brief Intervention

Practical 04 / Communication role-play

Aim

Carry out a non-judgemental substance use interview and agree on a follow-up action.

Principle

Consumption pattern, consequences, withdrawal risk, coexisting symptoms and readiness for change inform a patient-centred plan.

Materials and Requirements

- Role-play case and locally approved screening questions
- Referral and withdrawal escalation card

Procedure

1. Ask permission to discuss alcohol, nicotine or other substances. Clarify type, quantity, frequency, route and last use in ordinary language.
2. Check confidentiality and ask how use fits into the person's usual day. Quantify in ordinary units and confirm what, when and how often they use, then record uncertainty.
3. Explore function, previous attempts to change, past withdrawal and any serious symptoms. Check immediate safety and mental health concerns.
4. Ask about previous withdrawal symptoms, attempts to change and consequences at home or work. Check immediate physical and mental safety and flag any need for urgent clinical help.

Continue with step 5 on the next page.

Procedure Continued

Substance Use Assessment and Brief Intervention

5. If screening is appropriate, use the approved instrument and interpret it in context. Explain the relation between the stated concern and relevant risks.
6. Match the tool and time interval to the case and record relevant score and context. Discuss the association between the person's concern and use with permission.
7. Ask the patient what matters to them and which change feels possible. Discuss clinician-led review for dependence or withdrawal risk.
8. Ask which change the person wants to try and identify barriers or supports, including cost or time. Arrange clinician review before a plan for possible dependence or withdrawal.
9. Record the agreed follow-up, support and safety information. Use teach-back to confirm understanding.
10. Agree on one next action, contact and review date. Invite the person to repeat the plan and document their preferences and any warning signs discussed.

Precautions

- Use respectful descriptions. Avoid assuming that a screening score establishes a diagnosis.
- Escalate acute confusion, severe withdrawal or safety concerns immediately.

Observations and Interpretation

Substance Use Assessment and Brief Intervention

Observations and Record

Item	What to record	What it tells you
Exposure	Pattern, duration and last use	Supports risk assessment
Withdrawal history	Previous symptoms and time relation	Identifies risk requiring clinical review
Plan	Patient priority, support and follow-up	Makes the next step actionable

Worked Example

A patient wants to stop drinking and reports previous shaking when alcohol was stopped. They are concerned about missing work for treatment.

Result and Interpretation

Discuss potentially significant withdrawal risk and arrange clinician assessment before a cessation plan. Agree on support and an accessible appointment.

Viva Questions and Answers

Why ask for the time of last use?

It helps interpret intoxication or withdrawal symptoms.

What is teach-back?

Asking the person to explain the agreed plan in their own words.

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