



Guideline Summary NGC-4986

Guideline Title

Practice guideline for the psychiatric evaluation of adults.

Bibliographic Source(s)

American Psychiatric Association (APA). Practice guideline for the psychiatric evaluation of adults. 2nd ed. Washington (DC): American Psychiatric Association (APA); 2006 Jun. 62 p. [302 references]

Work Group on Psychiatric Evaluation, American Psychiatric Association Steering Committee on Practice Guidelines. Psychiatric evaluation of adults. Second edition. American Psychiatric Association. Am J Psychiatry 2006 Jun;163(6 Suppl):3-36. [302 references] [PubMed](#)

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Psychiatric Association (APA). Practice guideline for psychiatric evaluation of adults. Washington (DC): American Psychiatric Press, Inc; 1995. 28 p.

Practice guideline for psychiatric evaluation of adults. American Psychiatric Association (APA). Am J Psychiatry 1995 Nov;152(11 Suppl):63-80.

The American Psychiatric Association (APA) reaffirmed the currency of this guideline in 2011.

Scope

Disease/Condition(s)

Psychiatric illness

Guideline Category

Diagnosis

Evaluation

Management

Treatment

Clinical Specialty

Psychiatry

Intended Users

Physicians

Guideline Objective(s)

To assist physicians in clinical decision making in the setting of the 1) general psychiatric evaluation, 2) emergency evaluation, and 3) clinical consultation

Target Population

Adult patients, age 18 or older, although sections of the guideline may be applicable to younger patients

Interventions and Practices Considered

Psychiatric Evaluation*, Including General, Emergency, and Consultative Evaluations for Clinical Purposes

1. Patient interview
 - Use of interpreters
 - Interviews with agitated or aggressive individuals
2. Use of collateral sources

3. Use of structured interviews and rating scales, including functional assessments
4. Use of diagnostic tests, including psychological and neuropsychological tests
5. Physical examination
6. Working with multidisciplinary teams
7. Clinical formulation
 - Cultural formulation
 - Risk assessment
8. Differential diagnosis based on evaluation
9. Formulating an initial treatment plan
10. Making decisions regarding treatment-related legal and administrative issues
11. Consideration of systems issues
12. Special considerations regarding privacy and confidentiality, interactions with third-party payers and their agents, legal and administrative issues in institutions, special populations

*Note: Other psychiatric evaluations (including forensic, child custody, and disability evaluations) are not the focus of this guideline.

Major Outcomes Considered

Psychiatric evaluation and diagnoses

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Relevant literature was identified through a computerized search of MEDLINE, using PubMed, for the period from 1994 to 2005. The search strategy (psychiatric assessment OR psychiatric assessments OR psychiatric emergencies OR psychiatric emergency OR psychiatric evaluation OR psychiatric evaluations OR psychiatric histories OR psychiatric history OR psychiatric interview OR psychiatric interviewing OR psychiatric interviews OR psychological assessment OR psychological assessments OR psychological evaluation OR psychological interview OR mental status examination OR mental status examinations OR psychiatric rating) OR (mental disorders/diagnosis AND [laboratory findings OR laboratory techniques OR laboratory test OR laboratory tests OR radiograph OR radiographic OR radiography OR x ray OR imaging OR MRI OR tomography OR physical exam OR physical examination OR interview OR interviewing OR history taking OR evaluation OR assessment]) yielded 19,429 references of which 7,894 were published between 1994 and 2005 in English and had associated abstracts. An additional search on history taking AND (psychiatric OR sexual OR occupational OR social OR psychosocial) yielded 1,927 references, with 731 of these published with abstracts in English between the years 1994 and 2005.

Additional, more limited searches were conducted by American Psychiatric Association (APA) staff and individual members of the Work Group on Psychiatric Evaluation to address discrete issues outside of the primary guideline topic.

2011 Reaffirmation

A MEDLINE search, using PubMed, of all literature related to psychiatric evaluation topics was done for the years 2005 to 2010. In addition, a search of MEDLINE and PsycInfo for randomized controlled trials and meta-analyses for the years 1966 to September 2011 was done, using the EBSCO Host database, again on topics related to psychiatric evaluation.

Search results (approximately 95,000 articles) were screened for relevance by a single researcher, and a subset of the results (approximately 5,000 articles) were screened by a second researcher, demonstrating >90% concordance on ratings.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus (Committee)

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

The Work Group on Psychiatric Evaluation reviewed the literature search results in abstract. For relevant articles, the full text of the article was reviewed.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Step 1: The Steering Committee on Practice Guidelines selects about five individuals to serve as the Work Group on Psychiatric Evaluation chair and members.

Step 2: The work group chair and Department of Quality Improvement and Psychiatric Services staff develop a preliminary outline, to be continuously revised and refined throughout subsequent steps in the development process.

Step 3: A literature search is conducted by American Psychiatric Association (APA) and/or the work group. Relevant articles from the search are obtained, in abstract or in entirety. The work group reviews these articles.

Step 4: Draft 1 is written based on the literature review and outline.

Step 5: Draft 1 is circulated to the work group and Steering Committee for review and comment.

Step 6: Draft 2 is written based on comments received.

Step 7: Draft 2 is circulated for general review.

Step 8: Draft 3 is written based on comments received.

Step 9: Draft 3 is submitted to the formal APA review and approval process (Council on Quality Improvement, Assembly, Board of Trustees).

2011 Reaffirmation

Screened results from the literature search were reviewed by APA's practice guidelines medical editor, who concluded that no changes in evidence or practice since guideline publication could potentially change the recommendations in the 2006 guideline. The chair of the work group that developed the guideline and the chair of APA's Steering Committee on Practice Guidelines reviewed the guideline and concurred.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Each practice guideline is extensively reviewed at multiple draft stages. Draft 1 is reviewed by the Steering Committee. Draft 2 is reviewed by approximately 50 reviewers with expertise in the topic, representatives of allied organizations, the American Psychiatric Association (APA) Assembly, District Branches, the Joint Reference Committee, the Board of Trustees, the Council on Quality Care, other components related to the subject area, and any APA member by request. Draft 3 is reviewed and approved for publication by the Assembly and the Board of Trustees.

Fourteen organizations and 64 individuals are acknowledged in the original guideline document for having submitted significant comments to the draft guideline.

Recommendations

Major Recommendations

The purpose and conduct of a psychiatric evaluation depend on who requests the evaluation, why it is requested, and the expected future role of the psychiatrist in the patient's care. The outcome of the evaluation may or may not lead to a specific psychiatric diagnosis. Three types of clinical psychiatric evaluations are discussed: 1) general psychiatric evaluation, 2) emergency evaluation, and 3) clinical consultation. In addition, general principles to guide the conduct of evaluations for administrative or legal purposes are reviewed. At times there may be a conflict between the need to establish an effective working relationship with the patient and the need to obtain comprehensive information efficiently. If the psychiatrist expects to provide care directly to the patient, the establishment of an effective working relationship with the patient may take precedence over the comprehensiveness of the initial interview or interviews. In such a case, emphasis may be placed on obtaining information needed for immediate clinical recommendations and decisions.

Refer to the original guideline document for further discussion of the three types of clinical psychiatric evaluations, the sites of the clinical evaluation, and the domains of the clinical evaluation.

A. **Methods of Obtaining Information**

1. **Patient Interview**

The psychiatrist's primary assessment tool is the direct face-to-face interview of the patient. Evaluations based solely on review of records and interviews of persons close to the patient are inherently limited by a lack of the patient's perspective. Furthermore, the clinical interview provides the psychiatrist with a sample of the patient's interpersonal behavior and emotional processes. It can either support or qualify diagnostic inferences from the history and can also aid in prognosis and treatment planning. Important information can be derived by observing

the patient's general style of relating, the ways in which the patient minimizes or exaggerates certain aspects of his or her history, and whether particular questions appear to evoke hesitation or signs of discomfort. Additional observations concern the patient's ability to communicate about emotional issues, the defense mechanisms the patient uses when discussing emotionally important topics, and the patient's responses to the psychiatrist's comments and to other behavior, such as the psychiatrist's handling of interruptions or time limits.

The interview should be done in a manner that facilitates the patient's telling of his or her story, while simultaneously obtaining the necessary information. Time constraints need to be considered and adequate time allowed for the interview. High-priority tasks include an assessment of the patient's safety and the identification of signs, symptoms, or disorders requiring urgent treatment.

Opening with a discussion of the purpose of the interview offers the patient an understanding of the process. When the purpose is a general evaluation, beginning with open-ended, empathic inquiry about the patient's concerns usually is best. Attention to the patient's most pressing concerns, whenever possible, will improve the therapeutic alliance and is likely to facilitate increased patient cooperation; other inquiries may be more limited initially in the service of the alliance. Patient satisfaction with open-ended inquiry is greatest when the psychiatrist provides feedback to the patient at multiple points during the interview. Structured, systematic questioning has been shown to be especially helpful in eliciting information about substance use and traumatic life events and in ascertaining the presence or absence of specific symptoms and signs of particular mental disorders.

Throughout the interview, useful clinical information is obtained by being sensitive to issues of development, culture, race, ethnicity, primary language, health literacy, disabilities, gender, sexual orientation, familial/genetic patterns, religious and spiritual beliefs, social class, and physical and social environment influencing the patient's symptoms and behavior. Respectful evaluation involves an empathic, nonjudgmental attitude and appropriate responses concerning the patient's cultural identity, his or her own explanation of illness and treatment pathways, sociocultural stressors and supports, and modes of interpersonal communication, both verbal and nonverbal. An awareness of one's possible biases or prejudices about patients from different subcultures and an understanding of the limitations of one's knowledge and skills in working with such patients may help one determine when it is advisable to consult with a clinician who has expertise concerning a particular subculture.

a. Use of Interpreters in the Interview

When available, professionally trained interpreters with mental health experience should be used for encounters involving patients with limited English proficiency and those who are deaf or have severely limited hearing and who prefer to communicate using sign language. Bilingual and bicultural staff may also be helpful. With cooperative patients, over-the-phone language interpretation services can be used when other professionally trained interpreters are unavailable, although establishing rapport with the patient may be more difficult. Family members, community members, or friends should not be used unless the patient refuses to use the professional interpreter or under emergency circumstances, in which case this should be noted in the patient record. The interpreter should be instructed to translate the patient's own words and to avoid paraphrasing except as needed to translate the correct meaning of idioms and other culture-specific expressions.

b. Interviews with Agitated or Aggressive Individuals

When evaluating individuals who are agitated or aggressive, the psychiatrist needs to give consideration to the patient interview as well as to his or her own safety. Establishing the presence of backup personnel and choosing an appropriate space in which to conduct the interview are useful preparations before meeting with an agitated or aggressive patient. Because such individuals may become more agitated if they feel trapped within a small room or are too closely positioned to the interviewer, a distance of several arms' length from the patient, with both psychiatrist and patient having access to the door, is generally optimal. A safe office environment should not contain potentially dangerous objects (e.g., decorative items), and the clinician should avoid clothing that can be used against him or her (e.g., neckties, scarves, prominent dangling earrings). Depending on the configuration of the office or interview room and its proximity to other staff, a mechanism for summoning assistance (e.g., a panic button) may also be indicated.

During the interview, a nonconfrontational and straightforward approach is often most effective. Attending to the patient's comfort, using reflective or active listening techniques, and showing respect for the patient's feelings and stated concerns may aid in establishing rapport. The key to calming an aggressive patient is affect management. Patients who are affectively aroused will need to ventilate their feelings, and the clinician should allow the patient to tell his or her own story. Logical or rational responses to an affectively flooded individual may further inflame the patient. Affect management involves acknowledging the patient's affect, validating the affect when appropriate, and encouraging the patient to talk about his or her feelings.

In some circumstances, it may be appropriate to set limits (e.g., noting that aggressive behavior cannot be permitted) while simultaneously emphasizing the need to attend to the safety of the patient and others. Throughout the interview, the clinician needs to be alert for signs that the patient's agitation is escalating (e.g., increased body movements or pacing, clenched fists, verbal threats, or increasing verbal volume); such signs may indicate a need to adjust the interview style or timing. At times, it will be best to postpone in-depth history taking or discussion of distressing topics that are not germane to the patient's current presentation.

In some instances, administration of psychotropic medications or judicious use of seclusion or restraint may be necessary to enhance the safety of the patient and others or to permit essential physical examination, laboratory studies, or other diagnostic assessment. Reliance on such measures should be justified by the urgency of obtaining the diagnostic information and should be in compliance with applicable laws and regulations. The psychiatrist should consider how any special circumstances of the interview or examination may influence clinical findings. When the patient is able to cooperate, parts of the examination that cannot be completed or that are significantly influenced by the use of medication, seclusion, or restraint should be repeated if possible.

Guidelines for reducing the use of seclusion and restraint while at the same time maintaining the safety of patients and staff are available in a report developed by the APA with the American Psychiatric Nurses Association and the National Association of Psychiatric Health Systems. Recommendations of the report include assessing for anger management problems, identifying risk factors (e.g., pregnancy, asthma, head or spinal injury) before using restraint, identifying triggers, involving patients in treatment planning, asking

patients about past experiences of seclusion and restraint, involving family, and documenting interventions attempted before using seclusion or restraint.

2. Use of Collateral Sources

Family members, other important people in the patient's life, and records of prior medical and psychiatric treatment are frequently useful sources of information. Collateral information is particularly important when patients have impaired insight, including when patients have substance use disorders or cognitive impairment, and is essential for treatment planning when patients require a high level of assistance or supervision because of impaired function or unstable behavior. Family members and others who know the patient well may provide important information about the patient's personality before the onset of illness, since the patient's own account may be unduly influenced by his or her mental state. Collateral sources of information may also provide essential information about the illness course, the current symptoms and behavior, and the reasons for the evaluation. The extent of the collateral interviews and the extent of prior record review should be commensurate with the purpose of the evaluation, the complexity of the clinical presentation, and the diagnostic and therapeutic goals. For example, in an acute inpatient or emergency setting, collateral information may be crucial to developing an understanding of the patient's clinical condition, whereas in long-term outpatient psychotherapy the impact on the treatment process of obtaining collateral information from family or others needs to be considered. Except when immediate safety concerns are paramount, the confidentiality of the patient should be respected. At the same time, it is permissible for the psychiatrist to listen to information provided by family members and other important people in the patient's life, as long as confidential information is not provided to the informant.

3. Use of Structured Interviews and Rating Scales, Including Functional Assessments

Structured interviews, standardized data forms, questionnaires, and rating scales can be useful tools for diagnostic assessment and evaluation of treatment outcome. Table 3 in the original document, while not all-inclusive, lists many of the common structured instruments in use (see also the CD-ROM from APA's *Handbook of Psychiatric Measures*). Such structured instruments may be used as components for establishing a diagnosis, measuring social or occupational function, or monitoring changes in symptom severity or side effects over time during treatment.

Although most commonly used in psychiatric research, rating scales may also help psychiatrists structure a thorough line of questioning. In addition, self-report scales may be valuable in opening communication with patients about their symptoms, feelings, or experiences. At the same time, these tools vary considerably as to their reliability and validity. Potential cultural, ethnic, gender, social, and age biases are relevant to the selection of standardized interviews and rating scales and the interpretation of their results. Furthermore, clinical impressions of treatment response should consider the relative importance of specific symptoms to the patient's function and well-being and the relative impact of specific symptoms on the patient's social environment. Consequently, rating scales should never be used alone to establish a diagnosis or clinical treatment plan; they can augment but not supplant the clinician's evaluation, narrative, and clinical judgment.

For persons with chronic diseases, and particularly those with multiple comorbid conditions, structured assessment of physical and instrumental function may be useful in assessing strengths and disease severity. Functional assessments include assessment of physical activities of daily living (e.g., eating, using the toilet, transferring, bathing, and dressing) and instrumental activities of daily living (e.g., driving or using public transportation, taking medication as prescribed, shopping, managing one's own money, keeping house, communicating by mail or telephone, and caring for a child or other dependent). Impairments in these activities can be due to physical or cognitive impairment or to the disruption of purposeful activity by the symptoms of mental illness.

Formal assessment of physical and instrumental activities of daily living may be appropriate for patients who are disabled by old age or by chronic mental illness or general medical conditions. Such assessments facilitate the delineation of the combined effects of multiple illnesses and chronic conditions on patient's lives, and such assessments provide a severity measure that is congruent with patients' and families' experience of disability. In addition, functional assessment facilitates the monitoring of treatment by assessing important beneficial and adverse effects of treatment.

4. Use Of Diagnostic Tests, Including Psychological and Neuropsychological Tests

Laboratory tests are included in a psychiatric evaluation when they are necessary to establish or exclude a diagnosis, to aid in the choice of treatment, or to monitor treatment effects or side effects. When laboratory tests are obtained, relevant test results are documented in the evaluation, with their importance for diagnosis and treatment indicated in the clinical formulation or treatment plan.

Diagnostic tests used during a psychiatric evaluation include those that do the following:

1. **Detect or rule out the presence of a disorder or condition that has treatment consequences.** Examples include urine screens for substance use disorders, neuropsychological tests to ascertain the presence of a learning disability, and brain imaging tests to ascertain the presence of a structural neurological abnormality.
2. **Determine the relative safety and appropriate dose of potential alternative treatments.** For example, tests of hematological, thyroid, renal, and cardiac function in a patient with bipolar disorder may be needed to help the clinician choose among available mood-stabilizing medications, or evaluation of cardiac or pulmonary function may be important in determining a patient's medical status prior to electroconvulsive therapy.
3. **Provide baseline measurements before instituting treatment, with subsequent measurements used to assess for effects of treatment.** For example, baseline and follow-up electrocardiograms may be required to identify effects of antipsychotic or tricyclic antidepressant medications on cardiac conduction, whereas baseline and follow-up glucose levels and lipid panels may be required to identify effects of second-generation antipsychotic agents.
4. **Monitor blood levels of medications when indicated (e.g., for effectiveness, toxicity, or adherence).**

Under each of these circumstances, the potential utility of a test will be determined by multiple interrelated factors, including the following:

1. **The likelihood that an individual from a population of similar patients (e.g., of similar age, gender, treatment setting) would have the condition.** This probability is also referred to as the *prevalence* of the condition in that population. In general, conditions that are more prevalent in the population are more likely to be correctly identified by use of a diagnostic test. In the context of obtaining baseline measurements, the

likely prevalence of the condition at a later date may also be relevant.

2. **The probabilities that the test will correctly detect a condition that is present (true positive), incorrectly identify a condition as present when it is not (false positive), correctly identify a condition as absent (true negative), or incorrectly identify a condition as absent when it is actually present (false negative).** Although information about these probabilities is available for many tests, the key point to consider in clinical practice is that false negative and false positive test results do occur. Furthermore, incorrect identification of a condition can result in unnecessary and potentially detrimental evaluations and interventions; incorrectly viewing a condition as absent can lead to other crucial signs and symptoms of the condition being ignored.

3. **The treatment implications of the test results.** Obviously, a test will be of benefit if it correctly detects a previously unidentified and treatable condition. However, the treatment implications may be nil if the test correctly detects a condition that is already known to be present on the basis of clinical examination or history or if it correctly detects a benign or incidental condition that leads to further unnecessary testing with no beneficial effect on treatment.

Given the wide range of clinical situations evaluated by psychiatrists, there are no specific guidelines about which tests should be "routinely" done. It is important to have a clear rationale for the ordering of tests, and each patient should be considered individually. Nevertheless, some general principles may aid in deciding on particular diagnostic assessments. For example, tests may be ordered on the basis of the setting (e.g., some patients seen in emergency departments may be at increased risk for certain conditions that warrant diagnostic tests), the clinical presentation (e.g., certain tests are warranted for patients with new onset of delirium), or the potential treatments (e.g., patients may need certain tests before initiation of lithium therapy). For tests that require the patient's participation, factors such as language, education level, intelligence, culture, and level of alertness can affect the testing process and may influence the choice of diagnostic approaches. Patient preferences are also important to consider. Furthermore, the potential benefits of identifying and treating a particular condition need to be weighed against the costs (e.g., time, money, physical pain, emotional stress) of indiscriminate testing.

More detail on the use of laboratory testing to aid in diagnosis and to guide treatment is provided in APA practice guidelines for specific disorders. Table 4 in the original guideline document provides examples of and general indications for tests that may be indicated depending on the status of the patient.

Neuropsychological testing has a broad range of application, but the decision to order neuropsychological testing for an individual patient remains a matter of clinical judgment. Neuropsychological testing may be requested when cognitive deficits are suspected or there is a need to grade for severity or progression of deficits over time. In addition, neuropsychological testing can be helpful in distinguishing between cognitive disorders and malingering or factitious disorders. When patients present later in life with the new onset of psychosis or mood disorder accompanied by cognitive deficits, neuropsychological testing may also be helpful in distinguishing dementia from other psychiatric syndromes. In research studies, typical patterns of cognitive deficits have been identified in a variety of psychiatric disorders, including Alzheimer's disease, schizophrenia, bipolar disorder, major depressive disorder, and autism. Findings have highlighted the fact that cognitive deficits and associated impairment of social and occupational functioning may persist despite successful treatment of other core symptoms of an illness. For example, executive dysfunction may persist in otherwise responsive depression, and working memory may remain impaired in schizophrenia independent of response of positive and negative symptoms. Thus, for some patients, a better understanding of persistent neuropsychological impairments can aid in treatment and vocational planning.

5. Physical Examination

An understanding of the patient's general medical condition is important in order to 1) properly assess the patient's psychiatric symptoms and their potential cause, 2) determine the patient's need for general medical care, and 3) choose among psychiatric treatments that can be affected by the patient's general medical status. The psychiatrist also ensures that a recent medical workup with appropriate laboratory tests and monitoring is performed. The psychiatrist should be informed about the results of the medical workup and incorporate this information into the evaluation. The psychiatrist's close involvement in the patient's general medical evaluation and ongoing care can also improve the patient's care by promoting cooperation, facilitating follow-up, and permitting prompt reexamination of symptomatic areas when symptoms change.

The physical examination may be performed by the psychiatrist, another physician, or a medically trained clinician. Considerations influencing the decision of whether the psychiatrist will personally perform the physical examination include potential effects on the psychiatrist-patient relationship, the purposes of the evaluation, and the complexity of the medical condition of the patient. The timing, scope, and intensity will vary according to clinical circumstances. For example, the physical examination of an otherwise healthy patient with paranoia, or the genital-rectal examination of a patient with a history of sexual abuse, may be deferred to a more appropriate time and setting.

In most circumstances, the physical examination should be chaperoned. Particular caution is warranted in the physical examination of persons with histories of physical or sexual abuse or with other features that could increase the possibility of the patient's being distressed as a result of the examination (e.g., a patient with an erotic or paranoid transference to the psychiatrist). All but limited examinations of such patients should be chaperoned.

6. Work with Multidisciplinary Teams

In many settings, it has become commonplace for the care of psychiatric patients to draw on the expertise of multidisciplinary teams. In the evaluation phase of care, other members of the clinical team (e.g., nurses, psychologists, occupational therapists, social workers, case managers, peer counselors, chaplains) may gather data or perform discipline-specific assessments. The psychiatrist responsible for the patient's care reviews and integrates these assessments into the psychiatric evaluation of the patient and works with other members of the multidisciplinary team in developing and implementing a plan of care.

The opportunity to improve systematic observations of patients' behavior by staff is an advantage of controlled settings such as hospitals, partial hospital settings, residential treatment facilities, and other institutions. Several types of observations may be gathered, according to the patient's specific situation:

1. *General observations.* These are relevant to all patients in all settings and include notes on patients' behavior, statements and expressed concerns, cooperativeness with or resistance to staff, sleep/wake patterns, and self-care.

2. *Diagnosis-specific observations.* These are observations relevant to confirming a diagnosis or assessing the severity, complications, or subtype of a disorder. Examples include recording signs of withdrawal in an alcohol-dependent patient and observations during meals for patients with eating disorders.
3. *Patient-specific observations.* These are observations aimed at assessing a clinical hypothesis. An example is observation of behavior following a family meeting for a patient in whom family conflicts are suspected of having contributed to a psychotic relapse.
4. *Observations of response to treatment interventions.* Examples include systematic recording of a target behavior in a trial of behavior therapy, observations of the effects of newly prescribed medications, and nurse-completed rating scales to measure changes after behavioral or psychotherapeutic interventions.

B. **The Process of Assessment**

The actual assessment process during a psychiatric evaluation usually involves the development of initial impressions and hypotheses during the interview and their continual testing and refinement on the basis of information obtained throughout the interview and from mental status examination, diagnostic testing, and other sources.

1. **Clinical Formulation**

The integrative formulation aids in understanding the patient as a unique human being and allows the psychiatrist to appreciate the patient's environment, strengths, challenges, and coping skills. The formulation includes information specific to the patient that goes beyond what is conveyed in the diagnosis; it will vary in scope and depth with the purpose of the evaluation. Components of the formulation include phenomenological, neurobiological, psychological, and sociocultural issues involved in diagnosis and management. As relevant to each domain, the formulation will typically include a concise synthesis of what is known about the patient (e.g., individual characteristics, genetic predispositions, general medical conditions or laboratory abnormalities, past life experiences and developmental history, extent and quality of interpersonal relationships, central conflicts and defense mechanisms) and the patient's past and current symptomatology (including childhood or subsyndromal illness and predisposing, precipitating, perpetuating, or protecting factors) as well as the responses of symptoms to treatment. Variations in phenomenology with factors such as a patient's age or gender can be relevant in determining whether or not a behavior is indicative of psychopathology. Thus, the formulation may also include a discussion of the diagnostic, therapeutic, and prognostic implications of the evaluation findings.

a. *Cultural Formulation*

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, text revised (DSM-IV-TR) Outline for Cultural Formulation provides a systematic method of considering and incorporating sociocultural issues into the clinical formulation (see Table 5 in the original guideline document). Depending on the focus and extent of the evaluation, it may not be possible to do a complete cultural formulation based on the findings of the initial interview. However, when cultural issues emerge, they may be explored further during subsequent meetings with the patient. In addition, the information contained within the cultural formulation may be integrated with the other aspects of the clinical formulation or recorded as a separate element.

The cultural formulation begins with a review of the individual's cultural identity and includes the patient's self-construal of identity over time. Cultural identity involves not only ethnicity, acculturation/biculturality, and language but also age, gender, socioeconomic status, sexual orientation, religious and spiritual beliefs, disabilities, political orientation, and health literacy, among other factors.

Next, the formulation explores the role of the cultural context in the expression and evaluation of symptoms and dysfunction, including the patient's explanatory models or idioms of distress through which symptoms or needs may be communicated. These are assessed against the norms of the cultural reference group. Treatment experiences and preferences (including complementary and alternative medicine and indigenous approaches) are also identified. Cultural factors related to psychosocial stressors, available social supports, and levels of function or disability are also assessed; during this process, the roles of family/kin systems and religion and spirituality in providing emotional, instrumental, and informational support are highlighted.

The cultural formulation also includes specific consideration of cultural elements influencing the relationship between the individual and the clinician. In this regard, it is important for clinicians to cultivate an attitude of "cultural humility" in knowing their limits of knowledge and skills rather than reinforcing potentially damaging stereotypes and overgeneralizations. Differences in language, culture, or social status, as well as difficulties in identifying and understanding the cultural significance of behaviors or symptoms, may add to the complexities of the clinical encounter. Transference and countertransference may also be influenced by cultural considerations and may either aid or interfere with the treatment relationship. Further, the potential effect of the psychiatrist's sociocultural identity on the attitude and behavior of the patient should be taken into account in the subsequent formulation of a diagnostic opinion.

The cultural formulation concludes with an overall assessment of the ways in which these varied cultural considerations will specifically apply to differential diagnosis and treatment planning.

b. *Risk Assessment*

An additional component of the formulation involves an assessment of the patient's risk of harm to self or others. This may include consideration of suicide or homicide risk as well as other forms of self-injury (e.g., cutting behaviors, accidents), aggressive behaviors, neglect of self-care, or neglect of the care of dependents. The risk assessment is intended to identify specific factors that may increase or decrease a patient's degree of risk, thereby suggesting specific interventions that may modify particular risk factors or address the safety of the patient or others. Specific risk factors may include demographic parameters (e.g., age, gender), past behavior (e.g., suicide attempts, self-injury, aggression), psychiatric diagnoses, psychiatric symptoms (e.g., anxiety, hopelessness), co-occurring general medical conditions, sociocultural factors, psychosocial stressors, or individual strengths and vulnerabilities. For patients with suicidal behaviors, this risk assessment process is described in detail in APA's *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors*. Although standardized rating scales of suicidal or aggressive behaviors are often used in research and may suggest helpful lines of clinical inquiry, their utility in clinical risk assessment is limited by their low predictive value.

For individuals with dependent children, the risk assessment also includes an evaluation of the patient's capacity to parent. In addition to considering the number and ages of any children, the assessment reviews the patient's capacity to meet the needs of dependent children, both in general and during psychiatric crises if

these are likely to occur. The overall health, including mental health, of the children is also relevant, especially when the patient's psychiatric condition is likely to affect the children through genetic or psychosocial mechanisms or to impede the patient's ability to recognize and attend to the needs of a child.

2. Diagnosis

On the basis of information obtained in the evaluation, a differential diagnosis is developed. The differential diagnosis comprises conditions (including personality disorders or personality traits) described in the DSM-IV-TR, APA's current edition of DSM. A multiaxial system of diagnosis provides a convenient format for organizing and communicating the patient's current clinical status, other factors affecting the clinical situation, the patient's highest level of past functioning, and the patient's quality of life. General medical conditions are established through history, examination, diagnostic tests, medical records, and consultation.

The DSM classification and the specific diagnostic criteria are meant to serve as guidelines to be informed by clinical judgment in the categorization of the patient's condition(s) and are not meant to be applied in a rote fashion. To augment the DSM multiaxial approach, some clinicians also find it helpful to identify the patient's level of defensive functioning or incorporate dimensional or other approaches into their diagnostic assessments.

3. Initial Treatment Plan

The initial treatment plan addresses any specific diagnoses and psychiatric needs of the patient that have been identified during evaluation. If diagnostic or other questions have been posed or additional information is necessary, these issues should be addressed in the treatment plan.

The initial treatment plan begins with a determination of the appropriate treatment setting and includes an explicit statement of the diagnostic, therapeutic, and rehabilitative goals for treatment that includes short-term as well as longer-term goals. In the case of patients who initially will be treated in an inpatient or partial hospital setting, this implies apportioning the therapeutic task between a hospital phase and a posthospital phase. Within the acute care setting, some goals may be targeted for achievement within several days, whereas other goals will be targeted for completion by the time of discharge. On the basis of the goals, the plan specifies further diagnostic tests and procedures, further systematic observations or additional information to be obtained, and specific therapeutic modalities to be applied.

A comprehensive treatment plan addresses biological, psychological, and sociocultural domains. The psychiatrist can select from a range of individual, group, and family therapies to create an integrated multimodal treatment that includes biological and sociocultural interventions.

Quality care involves treatment plans that are safe, timely, effective, efficient, equitable (i.e., not influenced in quality by personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status), and person-centered. Such treatment plans encourage recovery from illness through community integration and empower patients to make choices that improve their quality of life. Thus, the treatment plan is ideally the result of collaboration between the patient, the psychiatrist, and other members of the treatment team as well as the primary care practitioner for patients who have an established source of primary care.

A range of potentially effective treatments is initially considered. More detailed consideration and documentation of the risks and benefits of treatment options may be needed in the following circumstances: when a relatively risky, costly, or unusual treatment is under consideration; when involved parties disagree about the optimal course of treatment; when the patient's motivation or capacity to benefit from potential treatment alternatives is in question; when the treatment would be involuntary or when other legal or administrative issues are involved; or when available treatment options are limited by external constraints (e.g., financial barriers, insurance restrictions, geographic barriers, service availability, the patient's capacity to participate in the proposed treatment). Such considerations are also relevant when considering the level of care needed to provide an individual patient with appropriate treatment. In addition, level-of-care determinations will vary with the diagnosis, the presence of co-occurring general medical or psychiatric disorders (including substance use disorders), the assessment of the patient's risk to self or others, the current severity of symptoms, the patient's prior illness course and complications, his or her psychosocial supports, his or her treatment adherence, and the strength of the therapeutic alliance, among other factors. In some circumstances, it is also important for the psychiatrist to be able to recognize the limitation of health care resources and demonstrate the ability to act as an advocate for patients within their sociocultural and financial constraints.

4. Decisions Regarding Treatment-Related Legal and Administrative Issues

Although the consideration of forensic evaluations is outside the scope of this practice guideline, there are times when the general psychiatric evaluation may need to address legal or administrative concerns (see "Special Considerations" in the original guideline document). Examples include deciding between voluntary and involuntary admission, determining whether legally mandated treatment should be pursued in objecting patients, determining whether there is a duty to protect (e.g., by modifying the patient's treatment, increasing outpatient visit frequency, initiating hospitalization, warning the victim) if the patient is deemed a potential risk to others, and deciding on the level of observation needed to address the patient's safety. In situations such as these, the psychiatrist's decision making will depend on the risk assessment (see "Risk Assessment" above) as well as other relevant aspects of the history, examination, symptoms, diagnosis, and clinical formulation. Assessment of the patient's decision-making capacity may also be needed as part of the informed consent process. When a patient's capacity to consent to treatment is uncertain, questioning to determine mental status should be extended to include items that test the patient's decision-making capacity. As with other aspects of the evaluation, it is important to document the rationales for making a particular treatment decision, including a discussion of supporting evidence from the evaluation findings.

5. Systems Issues

An assessment of family, peer networks, and other support systems is an important part of the psychiatric evaluation because of the potential role of these systems in ameliorating or augmenting the patient's signs and symptoms of illness. This is particularly true when evaluating individuals with complex bio-psychosocial challenges or serious psychiatric or general medical conditions. If the initial evaluation indicates that aspects of the care system have an important role in the patient's illness and treatment, goals are developed in response to these findings. Systems may be more open to considering change at times of crisis. Consequently, as well as generating goals for the patient's diagnosis and individual treatment, the evaluation may lead to goals for intervening with the family, other important people in the patient's life, other professionals (e.g., therapists), general medical providers, and governmental or social agencies (e.g., community mental health centers or family service agencies).

Specific plans may be needed for addressing problems in the care system that are seen as important to the patient's illness, symptoms, function, or well-being and that appear amenable to modification. For example, a parent may be unable to attend follow-up appointments unless issues relating to care of dependents are addressed; financial issues or formulary restrictions may preclude patients from obtaining their medications; or geographic constraints may limit access to a full range of treatment options. Plans to address such systems issues should consider feasibility, the patient's wishes, and the willingness of other people to be involved.

Refer to the original guideline document for a discussion of "special considerations," including privacy and confidentiality, interaction with third-party payers and their agents, legal and administrative issues in institutions, and special populations.

Clinical Algorithm(s)

None provided

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

The evidence base for practice guidelines is derived from two sources: research studies and clinical consensus. Where gaps exist in the research data, evidence is derived from clinical consensus, obtained through extensive review of multiple drafts of each guideline. In addition, each reference at the end of the original guideline document is followed by a letter code in brackets that indicates the nature of the supporting evidence, as follows:

- **[A]** *Double-blind, randomized clinical trial.* A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are blind to the assignments.
- **[A-]** *Randomized clinical trial.* Same as above but not double-blind.
- **[B]** *Clinical trial.* A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet standards for a randomized clinical trial.
- **[C]** *Cohort or longitudinal study.* A study in which subjects are prospectively followed over time without any specific intervention.
- **[D]** *Control study.* A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.
- **[E]** *Review with secondary analysis.* A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.
- **[F]** *Review.* A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.
- **[G]** *Other.* Textbooks, expert opinion, case reports, and other reports not included above.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate psychiatric evaluation in general and emergency situations and in clinical consultation

Potential Harms

- Incorrect identification of a condition can result in unnecessary and potentially detrimental evaluations and interventions.
- Incorrectly viewing a condition as absent can lead to other crucial signs and symptoms of the condition being ignored.

Qualifying Statements

Qualifying Statements

- This guideline is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual patient and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome for every individual, nor should they be interpreted as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.
- The guideline presumes familiarity with basic principles of psychiatric diagnosis and treatment planning as outlined in standard, contemporary psychiatric textbooks and taught in psychiatry residency training programs.
- While there is broad agreement that each element of the extensive general evaluation described in the guideline may be relevant or even crucial in a particular patient, the specific emphasis of an evaluation will vary according to its purpose and the patient's presenting problem. Consideration of the domains outlined in this guideline is part of a general psychiatric evaluation, but the content, process, and documentation must be determined by applying the professional skill and judgment of the psychiatrist. The performance of a particular set of clinical procedures does not

ensure the adequacy of a psychiatric evaluation, nor does their omission imply that the evaluation is deficient. The particular emphasis or modifications applied by the psychiatrist to the generic evaluation offered in this guideline should be consonant with the aims of the evaluation, the setting of practice, the patient's presenting problem, and the ever-evolving knowledge base concerning clinical assessment and clinical inference. Although documentation is an integral part of an evaluation, it is important to emphasize that the scope and detail of clinically appropriate documentation also will vary with the patient, setting, clinical situation, and confidentiality issues. Because of the wide variation in these factors, this guideline does not include recommendations regarding the content or frequency of documentation. Such determinations must be based on the specific circumstances of the evaluation.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Mobile Device Resources

Quick Reference Guides/Physician Guides

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain


Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

American Psychiatric Association (APA). Practice guideline for the psychiatric evaluation of adults. 2nd ed. Washington (DC): American Psychiatric Association (APA); 2006 Jun. 62 p. [302 references]

Work Group on Psychiatric Evaluation, American Psychiatric Association Steering Committee on Practice Guidelines. Psychiatric evaluation of adults. Second edition. American Psychiatric Association. Am J Psychiatry 2006 Jun;163(6 Suppl):3-36. [302 references] [PubMed](#) 

Adaptation

Not applicable: The guideline was not adapted from another source.

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Financial Disclosures/Conflicts of Interest

This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities some contributors, including work group members and reviewers, have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. Work group members are selected on the basis of their expertise and integrity. Any work group member or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work is asked to disclose this to the Steering Committee on Practice Guidelines and the work group. Iterative guideline drafts are reviewed by the Steering Committee, other experts, allied organizations, American Psychiatric Association (APA) members, and the APA Assembly and Board of Trustees; substantial revisions address or integrate the comments of these multiple reviewers. The development of the APA practice guidelines is not financially supported by any commercial organization.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Psychiatric Association (APA). Practice guideline for psychiatric evaluation of adults. Washington (DC): American Psychiatric Press, Inc; 1995. 28 p.

Practice guideline for psychiatric evaluation of adults. American Psychiatric Association (APA). Am J Psychiatry 1995 Nov; 152(11 Suppl):63-80.

The American Psychiatric Association (APA) reaffirmed the currency of this guideline in 2011.

Guideline Availability

Electronic copies: Available from the [American Psychiatric Association \(APA\) Web site](#).

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; fax (703) 907-1091

Availability of Companion Documents

The following are available:

- **Psychiatric evaluation of adults. Quick reference guide.** Arlington, VA: APA, 2006 Jun. Available from the [American Psychiatric Association \(APA\) Web site](#).
- **American Psychiatric Association practice guideline development process.** Washington, DC: APA, 2006 May. Available from the [APA Web site](#). Also available in a Personal Digital Assistant (PDA) version.

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; fax (703) 907-1091

Additionally, a continuing medical education (CME) course is available online at the [APA Web site](#).

Patient Resources

None available

NGC Status

This summary was completed by ECRI on December 1, 1998. The information was verified by the guideline developer on January 11, 1999. This NGC summary was updated by ECRI on July 5, 2006. The updated information was verified by the guideline developer on August 10, 2006. The currency of the guideline was reaffirmed by the developer in 2011 and this summary was updated by ECRI Institute on December 1, 2011.

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