PSYCHIATRIC
EVALUATION OF ADULTS
A Quick Reference Guide

Based on *Practice Guideline for the Psychiatric Evaluation of Adults,* Second Edition, originally published in June 2006. A guideline watch, summarizing significant developments in the scientific literature since publication of this guideline, may be available in the Psychiatric Practice section of the APA web site at www.psych.org.

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Statement of Intent

The Practice Guidelines and the Quick Reference Guides are 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 development of the APA Practice Guidelines and Quick Reference Guides has not been financially supported by any commercial organization. For more detail, see APA's "Practice Guideline Development Process," available as an appendix to the compendium of APA practice guidelines, published by APPI, and online at http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm.

OUTLINE

A. Purpose of the Evaluation

Psychiatric evaluations vary according to their purpose. This guide is intended primarily for general, emergency, and consultation evaluations for clinical purposes.

1. Establish aims of the evaluation.

- Assess and enhance safety and coordinate care.
- Establish whether a mental disorder is present.
- Collect data sufficient to support a differential diagnosis, including information from collateral sources.
- Collaborate with the patient to develop an initial treatment plan.
- Identify longer term issues for follow-up.

2. Expect general evaluations to be time intensive.

3. For consultations:

- Clarify the scope and purpose of the evaluation before proceeding with consultations relating to specific legal, administrative, or nonclinical questions, and discuss limits of confidentiality with the patient and the requester of the consultation.
- Provide clear and specific answers to (usually narrow) questions from the requester of a clinical consultation.
- Respect the patient's relationship with the primary clinician and encourage positive resolution of conflicts.

B. Site of the Evaluation

1. Adjust goals and evaluative approaches to the setting.

Settings include inpatient, outpatient, home, emergency, school, residential treatment, skilled nursing, long-term care, and correctional and other forensic settings.

2. Consider if the setting meets the needs of the patient.

For patients seen longitudinally, continually reassess to determine the appropriate level of care.

3. Document factors of the setting that may limit the evaluation.

Such factors may include lower level and quality of observation, compromised privacy, unavailability of interpreters for patients with limited English proficiency, unavailability of medical evaluations and diagnostic tests, and compromised safety and confidentiality.

4. Use inpatient settings to optimize safety, provide intensive and continuous observation, and provide multidisciplinary treatment and collaborative decision making.

It is important to assess the patient's current living environment on admission and identify resources to optimize care after discharge.

5. Use outpatient settings to provide greater patient autonomy and longitudinal perspective on the patient's symptoms.

- Consider helping the patient to obtain a primary care physician to enhance attention to co-occurring general medical conditions.
- With the patient's permission, involve the family and significant others, but be aware of conflicts that may interfere with support.
- Consider if observation from one-to-one interviews can be complemented by observations of the patient in a group setting.

C. Domains of the Evaluation

1. Understand that evaluations vary in scope and intensity.

2. Generally, consider the domains in Table 1 systematically.

3. Also consider aspects of the patient's developmental history that may be associated with an increased risk of later psychiatric illness (Table 2).

TABLE 1. Domains of the Clinical Evaluation

Domain	Questions to Consider
Reason for the evaluation	What is the patient's chief complaint and its duration? What reason does the patient give for seeking evaluation at this specific time? What reasons are given by other involved parties (e.g., family, other health professionals) for seeking evaluation at this specific time?
History of the present illness	What symptoms is the patient experiencing (e.g., worries; preoccupations; changes in mood; suspicions; delusions or hallucinatory experiences; recent changes in sleep, appetite, libido, concentration, memory, or behavior, including suicidal or aggressive behaviors)? What is the severity of the patient's symptoms? Over what time course have these symptoms developed or fluctuated? Are associated features of specific psychiatric syndromes (i.e., pertinent positive or negative factors) present or absent during the present illness? What factors does the patient believe are precipitating, aggravating, or otherwise modifying the illness or are temporally related to its course? Did the patient receive prior treatment for this episode of illness? Are other clinicians who care for the patient available to comment?
Psychiatric history	What is the chronology of past episodes of mental illness, regardless of whether such episodes were diagnosed or treated? What are the patient's previous sources of treatment, and what diagnoses were given? With respect to somatic therapies (e.g., medications, electroconvulsive therapy), what were the dose or treatment parameters, efficacy, side effects, treatment duration, and adherence? With respect to psychotherapy, what were the type, frequency, duration, adherence, and patient's perception of the therapeutic alliance and helpfulness of the psychotherapy? Is there a history of psychiatric hospitalization? Is there a history of suicide attempts or aggressive behaviors? Are past medical records available to consult?

TABLE 1. Domains of the Clinical Evaluation *(continued)*

Domain	Questions to Consider
History of alcohol and other substance use	What licit and illicit substances have been used, in what quantity, how frequently, and with what pattern and route of use? What functional, social, occupational, or legal consequences or self-perceived benefits of use have occurred? Has tolerance or withdrawal symptoms been noted? Has substance use been associated with psychiatric symptoms? Are family members available who could provide corroborating information about the patient's substance use and its consequences?
General medical history	What general medical illnesses are known, including hospitalizations, procedures, treatments, and medications? Are undiagnosed illnesses causing major distress or functional impairment? Does the patient engage in high-risk behaviors that would predispose him or her to a medical illness? Is the patient taking any prescribed or over-the-counter medications, herbal products, supplements, and/or vitamins? Has the patient experienced allergic reactions to or severe adverse effects of medications?
Developmental, psychosocial, and sociocultural history	What have been the most important events in the patient's life, and what were the patient's responses to them? What is the patient's history of formal education? What are the patient's cultural, religious, and spiritual beliefs, and how have these developed or changed over time? Is there a history of parental loss or divorce; physical, emotional, or sexual abuse; or exposure to other traumatic experiences? What strategies for coping has the patient used successfully during times of stress or adversity? During childhood or adolescence, did the patient have risk factors for any mental disorders? What has been the patient's capacity to maintain interpersonal relationships, and what is the patient's history of marital and other significant relationships? What is the patient's sexual history, including sexual orientation, beliefs, and practices? Does the patient have children?

TABLE 1. Domains of the Clinical Evaluation *(continued)*

Domain	Questions to Consider
Developmental, psychosocial, and sociocultural history *(continued)*	What past or current psychosocial stressors have affected the patient (including primary support group, social environment, education, occupation, housing, economic status, and access to health care)?
	What is the patient's capacity for self-care?
	What are the patient's sociocultural supports (e.g., family, friends, work, and religious and other community groups)?
	What are the patient's own interests, preferences, and values with respect to health care?
Occupational and military history	What is the patient's occupation, and what jobs has the patient held?
	What is the quality of the patient's work relationships?
	What work skills and strengths does the patient have?
	Is the patient unable to work due to disability?
	Regarding military service, what was the patient's status (volunteer, recruit, or draftee), did the patient experience combat, and did the patient suffer injury or trauma?
	Is the patient preparing for or adjusting to retirement?
Legal history	Does the patient have any past or current involvement with the legal system (e.g., warrants, arrests, detentions, convictions, probation, parole)?
	Do past or current legal problems relate to aggressive behaviors or substance intoxication?
	Has the patient had other significant interactions with the court system (e.g., family court, workers' compensation dispute, civil litigation, court-ordered psychiatric treatment)?
	Is past or current legal involvement a significant social stressor for the patient?
Family history	What information is available about general medical and psychiatric illnesses, including substance use disorders, in close relatives?
	Is there a family history of suicide or violent behavior?
	Are heritable illnesses present in family members that relate to the patient's presenting symptoms?
Review of systems	Is the patient having difficulty with sleep, appetite, eating patterns, or other vegetative symptoms, or with pain, neurological symptoms, or other systemic symptoms?

TABLE 1. Domains of the Clinical Evaluation *(continued)*

Domain	Questions to Consider
Review of systems *(continued)*	Does the patient have symptoms that suggest an undiagnosed medical illness that may be causing or contributing to psychiatric symptoms? Is the patient experiencing side effects from medications or other treatments?
Physical examination	What is the appropriate timing, scope, and intensity of the exam for this patient, and who is the most appropriate examiner? Upon examination, are there abnormalities in the patient's general appearance, vital signs, neurological status, skin, or organ systems? Is more detailed physical examination necessary to assess the patient for specific diseases?
Mental status examination	What symptoms and signs of a mental disorder is the patient currently exhibiting? What is the patient's general appearance and behavior? What are the characteristics of the patient's speech? What are the patient's mood and affect, including the stability, range, congruence, and appropriateness of affect? Are the patient's thought processes coherent? Are there recurrent or persistent themes in the patient's thought processes? Are there any abnormalities of the patient's thought content (e.g., delusions, ideas of reference, overvalued ideas, ruminations, obsessions, compulsions, phobias)? Is the patient having thoughts, plans, or intentions of harming self or others? Is the patient experiencing perceptual disturbances (e.g., hallucinations, illusions, derealization, depersonalization)? What is the patient's sensorium and level of cognitive function (e.g., orientation, attention, concentration, registration, short- and long-term memory, fund of knowledge, level of intelligence, drawing, abstract reasoning, language, and executive functions)? What is the patient's level of insight, judgment, and capacity for abstract reasoning? What is the patient's motivation to change his or her health risk behaviors?

TABLE 1. Domains of the Clinical Evaluation *(continued)*

Domain	Questions to Consider
Functional assessment	What are the patient's functional strengths, and what is the disease severity? To what degree can the patient perform physical activities of daily living (e.g., eating, toileting, transferring, bathing, dressing)? To what degree can the patient perform instrumental activities of daily living (e.g., driving, using public transportation, taking medications as prescribed, shopping, managing finances, keeping house, communicating by mail or telephone, caring for dependents)? Would a formal assessment of functioning be useful (e.g., to document deficits or aid continued monitoring)?
Diagnostic tests	What diagnostic tests are necessary to establish or exclude a diagnosis, aid in the choice of treatment, or monitor treatment effects or side effects?
Information derived from the interview process	Are symptoms minimized or exaggerated by the patient or others? Does the patient appear to provide accurate information? Do particular questions evoke hesitation or signs of discomfort? Is the patient able to communicate about emotional issues? How does the patient respond to the psychiatrist's comments and behaviors?

TABLE 2. Questions About Childhood Developmental History for Which Affirmative Answers May Indicate Increased Risk for Psychiatric Illness

Did the patient lose a parent at an early age?
Was there unusual or excessive separation anxiety during childhood or adolescence?
Were there significant problems with sleep?
Were there eating disturbances?
Were there problems making or keeping friends?
Was severe shyness a problem, including when interacting in peer groups?
Were there problems with being bullied or bullying?
Were there frequent disciplinary problems in school?
Were there serious difficulties with temper?
Were there many school absences for medical problems or any other problems?
Were there any delays in learning to read, write, or do math?
Were there serious problems paying attention, finishing school work, or completing homework?
Did the above problems lead to grade retention or special education intervention?

D. Process of the Evaluation

1. Methods of Obtaining Information

The psychiatrist's primary assessment tool is the direct face-to-face interview of the patient.

- Facilitate the patient's telling of his or her story.
- Consider time constraints. Attend to the patient's most pressing concerns.
- Use a combination of open-ended, empathic questioning and structured, systematic inquiry (e.g., about substance use, traumatic life events).
- Give high priority to assessment of safety and identification of signs, symptoms, and disorders requiring urgent treatment.
- Consider sociocultural issues.
- Use professionally trained interpreters with mental health experience, when available, for evaluation of patients with limited English proficiency and those who are deaf or have severely limited hearing and who know a sign language.

Consider using collateral sources such as family members, other important people in the patient's life, and records of prior general medical and psychiatric treatment.

- These sources of information are frequently useful, especially for patients with impaired insight, impaired function, or unstable behavior.
- Collateral sources may provide important information about the patient's premorbid personality, illness course, and reasons for the evaluation.
- Confidentiality should be respected. The psychiatrist may listen to input from collateral sources and ask questions without conveying confidential information to others.

Consider using structured interviews, psychological tests, forms, questionnaires, and rating scales.

- These tools can be useful for establishing a diagnosis, measuring social or occupational function, and monitoring changes in symptom severity or side effects over time during treatment.
- These tools vary as to their reliability and validity. Sociocultural and other issues may bias results and interpretation of results.
- Many clinical rating scales are available in APA's *Handbook of Psychiatric Measures,* published in 2000 by American Psychiatric Publishing, Inc.

Consider whether modifications in the evaluation are needed if the patient exhibits agitation or aggressive behavior.

- Attend to safety considerations (e.g., office configuration and environment, availability of and mechanisms for summoning backup personnel).
- Use a nonconfrontational approach that respects and addresses the patient's stated concerns, feelings, and affect.
- Remain alert for signs that agitation is escalating (e.g., increased body movements or pacing, clenched fists, verbal threats, or increasing verbal volume) and that the interview style or timing may require adjusting.
- Consider whether administration of psychotropic medications or judicious use of one-to-one nursing care or seclusion or restraint may be needed to enhance the safety of the patient and others or to permit essential physical examination, laboratory studies, or other diagnostic assessment.
- 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 APA with the American Psychiatric Nurses Association and the National Association of Psychiatric Health Systems (http://www.psych.org/psych_pract/treatg/pg/learningfromeachother.cfm).

1. Methods of Obtaining Information *(continued)*

Use diagnostic tests to help establish or exclude a diagnosis, aid in choice of treatment, or monitor treatment effects or side effects.

- Test utility will be determined by the prevalence of the condition in the population, the probability of error (i.e., a false positive or a false negative), and the treatment implications of the test results.
- It is important to have a clear rationale for ordering tests, and each patient must be considered individually.
- Table 3 lists tests that may be indicated in specific clinical situations.

TABLE 3. Tests That May Be Indicated as Part of a Psychiatric Evaluation

Test	Notes
Basic lab tests (e.g., complete blood count; blood chemistries including lipid profile, B_{12}, folate; urinalysis)	Used to screen for general medical conditions or provide baseline measures prior to treatment. Recommended frequency of screening may vary with health status and with specific ongoing treatments (e.g., second-generation antipsychotics, lithium).
Medication levels	Used to monitor therapeutic levels of medications.
Pregnancy test	Some psychiatric conditions and treatments may entail risks to a pregnant woman or her fetus.
Fasting blood glucose or hemoglobin A1c	Used to diagnose diabetes or help determine risk. Patients prescribed second-generation antipsychotics may be at increased risk.
Lyme serology, syphilis serology, HIV test	May assist in evaluation of cognitive and behavioral changes. Individuals with behavioral problems such as impulsivity or drug use may be at increased risk for HIV infection.
Thyroid function tests	May be important for patients with suspected mood disorder, anxiety disorder, or dementia. Used to monitor lithium effects.
Toxicology screen, blood alcohol level	Used to screen for substance use or abuse. Individuals with a mental disorder are at increased risk for substance abuse.
Lumbar puncture	Used to diagnose infection (e.g., meningitis, herpes, toxoplasmosis, syphilis, Lyme disease). May be important for differential diagnosis of delirium.

TABLE 3. Tests That May Be Indicated as Part of a Psychiatric Evaluation *(continued)*

Test	Notes
Electrocardiogram	Used to assess effects of medications that may influence cardiac conduction (e.g., tricyclic antidepressants, some antipsychotics). May also be indicated depending on age and health status.
Chest X-ray	Used to diagnose cardiopulmonary disorders (e.g., pneumonia, tuberculosis) that may contribute to delirium. May also be part of a pre-ECT evaluation depending on age and health status.
Imaging studies	Structural (e.g., CT, MRI) and functional (e.g., PET, SPECT, EEG, fMRI) studies may indicate regional brain abnormalities related to a psychiatric illness and its management.
Polysomnography	Used to diagnose sleep disorders, including sleep apnea. May be important for differential diagnosis of depression, psychosis, or other cognitive or behavioral changes.
Psychological testing	May be requested when cognitive deficits are suspected or there is need to grade for severity or progression of symptoms over time. May also be helpful in establishing a diagnosis (e.g., dementia, mental retardation) or in delineating specific deficits that affect thought processes, treatment, or vocational planning.

Perform or request a physical examination as needed.

- The patient's general medical condition may 1) influence or cause psychiatric symptoms, 2) require general medical care, and 3) affect choice of psychiatric treatment.
- When appropriate, the psychiatrist should ensure that indicated medical assessments are done and incorporate these findings into the evaluation.
- The physical examination may be performed by the psychiatrist, another physician, or a medically trained clinician.
- In most circumstances, the physical examination should be chaperoned.

Collaborate with members of multidisciplinary teams who are involved in caring for the patient and making observations about the patient's behavior and symptoms.

2. The Process of Assessment

Perform an integrative clinical formulation and risk assessment.

- The formulation aids in understanding the patient as a unique human being and appreciating individual strengths and challenges.
- Consider phenomenological, neurobiological, psychological, and sociocultural issues involved in diagnosis and management.
- Consider using the DSM-IV-TR Outline for Cultural Formulation (Table 4) to address sociocultural issues.
- In assessing the patient's risk of harm to self or others, consider suicide or homicide risk, other forms of self-injury (e.g., cutting behaviors, accidents), aggressive behaviors, neglect of self-care, and neglect of the care of dependents. Identify specific risk factors that may be modifiable by intervention.

TABLE 4. Components of a Cultural Formulation

Cultural identity of the individual
Cultural explanations of the individual's illness
Cultural factors related to psychosocial environment and levels of functioning
Cultural elements of the relationship between the individual and the clinician
Overall cultural assessment for diagnosis and care

Source. From DSM-IV-TR, pp. 897–898.

Determine a diagnosis.

- Develop a differential diagnosis based on the information obtained in the evaluation and summarized in the integrative clinical formulation.
- Use the DSM multiaxial system of diagnosis as a method for organizing and communicating the patient's current clinical status.
- To augment the DSM multiaxial approach, consider identifying the patient's level of defensive functioning or incorporate dimensional approaches into the diagnostic assessment.

Establish a comprehensive initial treatment plan that addresses biopsychosocial domains.

- The plan is ideally the result of collaboration among the patient, the psychiatrist, and other members of the treatment team, including the primary care physician.
- Establish both short- and long-term diagnostic, therapeutic, and rehabilitative goals.
- Consider risks and benefits of potential treatment approaches.
- If resources limit treatment options, consider advocating for the patient to obtain what is needed.

Address legal or administrative concerns as needed (e.g., involuntary admission, duty to protect, level of observation).

Assess family, peer networks, and other support systems.

E. Special Considerations

1. Maintain the patient's privacy and confidentiality.

- In general, maintain confidentiality unless the patient gives consent to a specific communication.
- Under specific clinical circumstances, confidentiality may be attenuated to address the safety of the patient and others.
- According to the Health Insurance Portability and Accountability Act (HIPAA), information from medical records may be released without a specific consent form for purposes of "treatment, payment, and health care operations." Otherwise, patients must sign an authorization form.
- When releasing information to third-party payers (e.g., for utilization review or preauthorization decision), it may be important to request specific rather than blanket consent from the patient.
- Psychotherapy notes have special protection under HIPAA.
- Release of information about individuals evaluated or treated for substance use disorders is governed by the provisions of 42 CFR §2.11.

2. Address legal and administrative issues.

- When a patient is admitted to a hospital or other residential setting, clarify legal status and establish whether the admission is voluntary or involuntary.
- Determine if the patient gives or withholds consent to evaluation and treatment.
- Determine if the patient is able to make treatment-related decisions and whether an advance directive (e.g., concerning psychiatric or end-of-life treatment) has been executed.
- If fiscal and administrative issues constrain treatment options, inform the patient, family, and others, including third-party payers, and attempt to find alternatives.

3. Understand and address the needs of patients from special populations.

- Evaluation of elderly patients or patients with medical conditions may emphasize general medical history, cognitive mental status, and level of functioning.
- Evaluation of incarcerated persons may emphasize legal history, previous episodes of incarceration, and alcohol and substance use history. Risk assessment is crucial, because suicide is one of the leading causes of death in correctional settings.
- In overcoming mistrust and fear, engagement of homeless persons over numerous, brief, and seemingly casual interactions in nonclinical settings may precede a formal evaluation.
- Use professionally trained interpreters with mental health experience, when available, for evaluation of patients with limited English proficiency and those who are deaf or have severely limited hearing and who know a sign language.
- Evaluation of persons with mental retardation may emphasize behavioral observations or functional measures, depending on the patient's ability to understand questions and report on his or her own mental experiences. Co-occurring general medical conditions are often undetected in adults with mental retardation.