

The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults

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At its December meeting, The APA Board of Trustees approved the APA Work Group on Psychiatric Evaluation's Practice Guidelines for the Psychiatric Evaluation of Adults. [The full guideline is available at <http://psychiatryonline.org/doi/book/10.1176/appi.books.9780890426760>].

BACKGROUND AND DEVELOPMENT PROCESS

These Practice Guidelines for the Psychiatric Evaluation of Adults mark a transition in the American Psychiatric Association's Practice Guidelines. Since the publication of the 2011 Institute of Medicine report *Clinical Practice Guidelines We Can Trust*, there has been an increasing focus on using clearly defined, transparent processes for rating the quality of evidence and the strength of the overall body of evidence in systematic reviews of the scientific literature. These guidelines were developed using a process intended to be consistent with the recommendations of the Institute of Medicine (2011), the Principles for the Development of Specialty Society Clinical Guidelines of the Council of Medical Specialty Societies (2012), and the requirements of the Agency for Healthcare Research and Quality (AHRQ) for inclusion of a guideline in the National Guideline Clearinghouse. Parameters used for the guidelines' systematic review are included with the full text of the guidelines; the development process is fully described in a document available on the APA website: <http://www.psychiatry.org/File%20Library/Practice/APA-Guideline-Development-Process%20updated-2011-.pdf>. To supplement the expertise of members of the guideline work group, we used a "snowball" survey methodology to identify experts on psychiatric evaluation and solicit their input on aspects of the psychiatric evaluation that they saw as likely to improve specific patient outcomes (Yager 2014). Results of this expert survey are included with the full text of the practice guideline.

Rating the strength of research evidence and recommendations

The new guideline recommendations are rated using GRADE (Grading of Recommendations Assessment, Development and Evaluation), an approach adopted by multiple professional organizations around the world to develop practice guideline recommendations (Guyatt et al., 2013). With the GRADE

approach, the strength of a guideline statement reflects the level of confidence that potential benefits of an intervention outweigh the potential harms (Andrews et al., 2013). This level of confidence is informed by available evidence, which includes evidence from clinical trials as well as expert opinion and patient values and preferences. Evidence for the benefit of a particular intervention within a specific clinical context is identified through systematic review and is then balanced against the evidence for harms. In this regard, harms are broadly defined and might include direct and indirect costs of the intervention (including opportunity costs) as well as potential for adverse effects from the intervention. Whenever possible, we have followed the admonition to current guideline development groups to avoid using words such as "might" or "consider" in drafting these recommendations as they can be difficult for clinicians to interpret (Shiffman et al., 2005).

As described under "Guideline Development Process," each final rating is a consensus judgment of the authors of the guidelines and is endorsed by the APA Board of Trustees. A "recommendation" (denoted by the numeral 1 after the guideline statement) indicates confidence that the benefits of the intervention clearly outweigh harms. A "suggestion" (denoted by the numeral 2 after the guideline statement) indicates uncertainty (i.e., the balance of benefits and harms is difficult to judge, or either the benefits or the harms are unclear). Each guideline statement also has an associated rating for the "strength of supporting research evidence." Three ratings are used: high, moderate, or low (denoted by the letters A, B and C, respectively) and reflect the level of confidence that the evidence reflects a true effect based on consistency of findings across studies, directness of the effect on a specific health outcome, and precision of the estimate of effect and risk of bias in available studies (AHRQ 2014; Balshem et al. 2011; Guyatt et al. 2006).

It is well recognized that there are guideline topics and clinical circumstances for which high quality evidence from clinical trials is not possible or is unethical to obtain (Council of Medical Specialty Societies, 2012). For example, it would not be ethical to randomly assign only half of patients with depression to be asked about suicidal ideas. Many questions need to be asked as part of the assessment, and inquiring about a particular symptom or element of the history cannot

be separated out for study as a discrete intervention. It would also be impossible to separate changes in outcome due to assessment from changes in outcomes due to ensuing treatment. Research on psychiatric assessment is also complicated by multiple confounding factors such as the interaction between the clinician and the patient or the patient's unique circumstances and experiences. For these and other reasons, the vast majority of topics covered in these guidelines on psychiatric evaluation have relied on forms of evidence such as consensus opinions of experienced clinicians or indirect findings from observational studies rather than being based on research from randomized trials. The GRADE working group and guidelines developed by other professional organizations have noted that a strong recommendation may be appropriate even in the absence of research evidence when sensible alternatives do not exist (Andrews et al. 2013; Brito et al. 2013; Djulbegovic et al. 2009; Hazlehurst et al. 2013).

Goals and scope of guidelines for the psychiatric evaluation of adults

Despite the difficulties in obtaining quantitative evidence from randomized trials for practice guidelines such as psychiatric evaluation, guidance to clinicians can still be beneficial in enhancing care to patients. Thus, in the context of an initial psychiatric evaluation, a major goal of these guidelines is to improve the identification of psychiatric signs and symptoms, psychiatric disorders (including substance use disorders), other medical conditions (that could affect the accuracy of a psychiatric diagnosis), and patients who are at increased risk for suicidal or aggressive behaviors. Additional goals relate to identifying factors that could influence the therapeutic alliance, enhance clinical decisionmaking, enable safe and appropriate treatment planning, and promote better treatment outcomes. Finally, the psychiatric evaluation is the start of a dialog with patients about many factors, including diagnosis and treatment options. Further goals of these guidelines are to improve collaborative decisionmaking between patients and clinicians about treatment-related decisions as well as to increase coordination of psychiatric treatment with other clinicians who may be involved in the patient's care.

Time required to complete a psychiatric evaluation

It is essential to note that these guidelines are not intended to be comprehensive in scope. Many critical aspects of the psychiatric evaluation are not addressed by these guidelines. For example, it is assumed that initial psychiatric or other medical assessments will need to identify the reason that the patient is presenting for evaluation. It is similarly important to understand the patient's background, relationships, life circumstances, strengths and vulnerabilities.

Furthermore, depending on the context, recommended areas of inquiry may need to be postponed until later visits, and recommended questions will not always be indicated for a specific patient. The findings of the expert survey reiterate that experts vary in the extent to which particular elements of the initial psychiatric evaluation are assessed. This also

highlights the importance of clinical judgment in tailoring the psychiatric evaluation to the unique circumstances of the patient and in determining which questions are most important to ask as part of an initial assessment.

Proper use of guidelines

The American Psychiatric Association Practice Guidelines are not intended to serve or be construed as a "standard of medical care." Judgments concerning clinical care depend on the clinical circumstances and data available for an individual patient and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These guideline statements were determined on the basis of the relative balance of potential benefits and harms of a specific assessment, intervention or other approach to care. As such, it is not possible to draw conclusions about the effects of omitting a particular recommendation, either in general or for a specific patient. Furthermore, adherence to these guidelines will not ensure a successful outcome for every individual, nor should these guidelines be interpreted as including all proper methods of evaluation and care or excluding other acceptable methods of evaluation and care aimed at the same results. The ultimate recommendation regarding a particular assessment, clinical procedure, or treatment plan must be made by the psychiatrist in light of the psychiatric evaluation, other clinical data, and the diagnostic and treatment options available. Such recommendations should be made in collaboration with the patient and family, whenever possible, and incorporate the patient's personal and sociocultural preferences and values in order to enhance the therapeutic alliance, adherence to treatment, and treatment outcomes.

Organization of the practice guidelines for the psychiatric evaluation of adults

As part of aligning the practice guidelines' development process with national standards, we have transitioned to a new guideline format. Each set of Practice Guidelines will consist of multiple discrete topics of relevance to an overall subject area. In the Practice Guidelines for the Psychiatric Evaluation of Adults, these topics consist of Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History; Substance Use Assessment; Assessment of Suicide Risk; Assessment of Risk for Aggressive Behaviors; Assessment of Cultural Factors; Assessment of Medical Health; Quantitative Assessment; Involvement of the Patient in Treatment Decision Making; and Documentation of the Psychiatric Evaluation. For each topic, guideline statements will be followed by a discussion of the rationale, potential benefits and harms, and approaches to implementing the guideline statements. This portion of the Practice Guidelines is expected have the greatest utility for clinicians. A second section of the Practice Guidelines provides a detailed review of the evidence for guideline statements in accord with national guideline development standards. This review of research evidence and data from the expert survey is followed by a discussion of quality measurement considerations, including their appropriateness for each topic.

TABLE 1. Practice Guidelines for the Psychiatric Evaluation of Adults

Guideline	Title
I	Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History
II	Substance Use Assessment
III	Assessment of Suicide Risk
IV	Assessment of Risk for Aggressive Behaviors
V	Assessment of Cultural Factors
VI	Assessment of Medical Health
VII	Quantitative Assessment
VIII	Involvement of the Patient in Treatment Decision-Making
IX	Documentation of the Psychiatric Evaluation

GUIDELINES AND STATEMENTS

The following represents a summary of the recommendations and suggestions compiled from all Practice Guidelines for the Psychiatric Evaluation of Adults (Table 1), with some statements being a part of more than one of these guidelines. In the context of these guideline statements, it is important to note that assessment is not limited to direct examination of the patient. Rather, it is defined as “the process of obtaining information about a patient through any of a variety of methods, including face-to-face interview, review of medical records, physical examination (by the psychiatrist, another physician, or a medically trained clinician), diagnostic testing, or history-taking from collateral sources.” The evaluation may also require several meetings, with the patient, family, or others, before it can be completed. The amount of time spent depends on the complexity of the problem, the clinical setting, and the patient’s ability and willingness to cooperate with the assessment.

This summary is organized according to common headings of an evaluation note. As noted above, the guidelines are not intended to be comprehensive, and many aspects of the psychiatric evaluation are not addressed by these recommendations and suggestions. The strength of supporting research evidence for these recommendations and suggestions is given rating C (low) because of the difficulties in studying psychiatric assessment approaches in controlled studies as described in the “Background and Development Process.” The specific guideline(s) in which the recommendation or suggestion is found is denoted by its Roman numeral from Table 1.

History of present illness

In addition to reasons that the patient is presenting for evaluation, APA recommends (1C) that the initial psychiatric evaluation of a patient include:

- Psychiatric review of systems (I), including anxiety symptoms and panic attacks (III)
- Assessment of past or current sleep abnormalities, including sleep apnea (VI)
- Assessment of impulsivity (III, IV)

Psychiatric history

APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:

- Past and current psychiatric diagnoses (I, III)
- Prior psychotic or aggressive ideas, including thoughts of physical or sexual aggression or homicide (IV)
- Prior aggressive behaviors (e.g., homicide, domestic or workplace violence, other physically or sexually aggressive threats or acts) (IV)
- Prior suicidal ideas, suicide plans, and suicide attempts, including attempts that were aborted or interrupted as well as the details of each attempt (e.g., context, method, damage, potential lethality, intent) (III)
- Prior intentional self-injury in which there was no suicidal intent (III)

APA recommends (1C) that the initial psychiatric evaluation of a patient include review of the following aspects of the patient’s psychiatric treatment history:

- History of psychiatric hospitalization and emergency department visits for psychiatric issues (I, III, IV)
- Past psychiatric treatments (type, duration, and, where applicable, doses) (I)
- Response to past psychiatric treatments (I)
- Adherence to past and current pharmacological and non-pharmacological psychiatric treatments (I)

Substance use history

APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:

- The patient’s use of tobacco, alcohol, and other substances (e.g., marijuana, cocaine, heroin, hallucinogens) and any misuse of prescribed or over-the-counter medications or supplements (II)
- Current or recent substance use disorder or change in use of alcohol or other substances (III, IV)

Medical history (VI). APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:

- Allergies or drug sensitivities
- All medications the patient is currently or recently taking and the side effects of these medications (i.e., both prescribed and nonprescribed medications, herbal and nutritional supplements, and vitamins)
- Whether or not the patient has an ongoing relationship with a primary care health professional
- Past or current medical illnesses and related hospitalizations
- Relevant past or current treatments, including surgeries, other procedures, or complementary and alternative medical treatments
- Past or current neurological or neurocognitive disorders or symptoms (IV)
- Physical trauma, including head injuries
- Sexual and reproductive history

APA suggests (2C) that the initial psychiatric evaluation of a patient also include assessment of the following:

- Cardiopulmonary status
- Past or current endocrinological disease
- Past or current infectious disease, including sexually transmitted diseases, HIV, tuberculosis, hepatitis C, and locally endemic infectious diseases such as Lyme disease
- Past or current symptoms or conditions associated with significant pain and discomfort

Review of systems (VI). APA recommends (1C) that the initial psychiatric evaluation of a patient include a psychiatric review of systems (if not already included with history of present illness)

In addition to a psychiatric review of systems, APA suggests (2C) that the initial psychiatric evaluation of a patient include a review of the following systems:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Endocrine
- Hematological/Lymphatic
- Allergic/Immunological

Family history

APA recommends (1C) that the initial psychiatric evaluation of a patient *who reports current suicidal ideas* include assessment of history of suicidal behaviors in biological relatives (for patients with current suicidal ideas) (III)

When it is determined during an initial psychiatric evaluation that the patient has aggressive ideas, APA recommends (1C) assessment of history of violent behaviors in biological relatives (for patients with current aggressive ideas) (IV)

Personal and social history

APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:

- Presence of psychosocial stressors, (e.g. financial, housing, legal, school/occupational or interpersonal/relationship problems; lack of social support; painful, disfiguring, or terminal medical illness) (III, IV)
- Review of the patient's trauma history (I, III)
- Exposure to violence or aggressive behavior, including combat exposure or childhood abuse (IV)
- Legal or disciplinary consequences of past aggressive behaviors (IV)

- Cultural factors related to the patient's social environment (V)
- Patient's need for an interpreter (V)

APA suggests (2C) that the initial psychiatric evaluation of a patient include assessment of the patient's Personal/cultural beliefs and cultural explanations of psychiatric illness (V)

Examination, including mental status examination

APA suggests (2C) that the initial psychiatric evaluation of a patient also include assessment of the following:

- Height, weight, and body mass index (BMI) (VI)
- Vital signs (VI)
- Skin, including any stigmata of trauma, self-injury, or drug use (VI)

APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:

- General appearance and nutritional status (VI)
- Coordination and gait (VI)
- Involuntary movements or abnormalities of motor tone (VI)
- Sight and hearing (VI)
- Speech, including fluency and articulation (VI)
- Mood, level of anxiety, thought content and process, and perception and cognition (I, III)
- Hopelessness (III)
- Current suicidal ideas, suicide plans, and suicide attempts, including active or passive thoughts of suicide or death (III): If current suicidal ideas are present, assess:
 - Patient's intended course of action if current symptoms worsen
 - Access to suicide methods including firearms
 - Patient's possible motivations for suicide (e.g. attention or reaction from others, revenge, shame, humiliation, delusional guilt, command hallucinations)
 - Reasons for living (e.g. sense of responsibility to children or others, religious beliefs)
 - Quality and strength of the therapeutic alliance
- Current aggressive or psychotic ideas, including thoughts of physical or sexual aggression or homicide (III, IV): If current aggressive ideas are present, assess:
 - Specific individuals or groups toward whom homicidal or aggressive ideas or behaviors have been directed in the past or at present
 - Impulsivity, including anger management issues
 - Access to firearms

Impression and plan

APA recommends (1C) that the clinician who conducts the initial psychiatric evaluation document:

- An estimate of the patient's suicide risk, including factors influencing risk (III)
- The rationale for treatment selection, including discussion of the specific factors that influenced the treatment choice (IX)

APA recommends (1C) that the initial psychiatric evaluation of a patient who is seen include:

- Asking the patient about treatment-related preferences (VIII)
- An explanation to the patient of the following: the differential diagnosis, risks of untreated illness, treatment options, and benefits and risks of treatment (VIII)
- Collaboration between the clinician and the patient about decisions pertinent to treatment (VIII)

APA suggests (2C) that the initial psychiatric evaluation of a patient include:

- Quantitative measures of symptoms, level of functioning, and quality of life (VII)
- Documentation of an estimated risk of aggressive behavior (including homicide), including factors influencing risk (IV)
- Documentation of the rationale for clinical tests (IX)

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