**National Quality Forum—Evidence (subcriterion 1a)**

**Measure Number** (*if previously endorsed*)**:** 1922

**Measure Title**: Admission Screening

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** Click here to enter composite measure #/ title

**Date of Submission**: 12/20/2018

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| **Instructions**  *Complete 1a.1 and 1a.2 for all measures. If instrument-based measure, complete 1a.3.*  *Complete* ***EITHER 1a.2, 1a.3 or 1a.4*** *as applicable for the type of measure and evidence.*  *For composite performance measures:*  *A separate evidence form is required for each component measure unless several components were studied together.*  *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*   * All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

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| **Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF’s evaluation criteria.**   1a. Evidence to Support the Measure Focus The measure focus is evidence-based, demonstrated as follows:   * Outcome: [**3**](#Note3) Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias. * Intermediate clinical outcome: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4)that the measured intermediate clinical outcome leads to a desired health outcome. * Process: [**5**](#Note5) a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured process leads to a desired health outcome. * Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured structure leads to a desired health outcome. * Efficiency: [**6**](#Note6) evidence not required for the resource use component. * For measures derived from patient reports, evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful. * Process measures incorporating Appropriate Use Criteria: See NQF’s guidance for evidence for measures, in general; guidance for measures specifically based on clinical practice guidelines apply as well.   **Notes**  **3.** Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.  **4.** The preferred systems for grading the evidence are the Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org) and/or modified GRADE.  **5.** Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.  **6.** Measures of efficiency combine the concepts of resource use and quality (see NQF’s [Measurement Framework: Evaluating Efficiency Across Episodes of Care](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx); [AQA Principles of Efficiency Measures](http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc)). |

**1a.1.This is a measure of**: (*should be consistent with type of measure entered in De.1*)

Outcome

Outcome: Click here to name the health outcome

Patient-reported outcome (PRO): Click here to name the PRO

*PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors.* (*A PRO-based performance measure is not a survey instrument. Data may be collected using a survey instrument to construct a PRO measure.)*

Intermediate clinical outcome (*e.g., lab value*): Click here to name the intermediate outcome

Process: Click here to name what is being measured

Appropriate use measure: Click here to name what is being measured

Structure: Click here to name the structure

Composite: Click here to name what is being measured

**1a.2** **LOGIC MODEL** Diagram or briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient’s health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

The focus of the measure is to evaluate all psychiatric inpatients to determine whether admission screenings are completed for violence risk to self and others, substance use, psychological trauma history and patient strengths to help to develop an initial treatment plan that will incorporate these findings and thereby promote treatment adherence and reduce the likelihood of psychiatric relapse and improve medication compliance, thus reducing the overall cost of ongoing recovery.

**1a.3** **Value and Meaningfulness:**  **IF** this measure is derived from patient report, provide evidence that the target population values the measured ***outcome, process, or structure*** and finds it meaningful. (Describe how and from whom their input was obtained.)

Not applicable

**\*\*RESPOND TO ONLY ONE SECTION BELOW -EITHER 1a.2, 1a.3 or 1a.4) \*\***

**1a.2** **FOR OUTCOME MEASURES including PATIENT REPORTED OUTCOMES - Provide empirical data demonstrating the relationship between the outcome (or PRO) to at least one healthcare structure, process, intervention, or service.**

Not applicable

**1a.3.****SYSTEMATIC REVIEW(SR) OF THE EVIDENCE (for intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measures, including those that are instrument-based) If the evidence is not based on a systematic review go to section 1a.4) If you wish to include more than one systematic review, add additional tables.**

**What is the source of the systematic review of the body of evidence that supports the performance measure? A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data. (IOM)**

☐ Clinical Practice Guideline recommendation (with evidence review)

☐ US Preventive Services Task Force Recommendation

☐ Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*)

☐ Other

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| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | **Title:** Practice Guidelines for the Psychiatric Evaluation of Adults Third Edition  **Author:** American Psychiatric Association Work Group on Psychiatric Evaluation  **Date:** 2016  **Citation including page number:** American Psychiatric Association (2016).  Practice Guidelines for the Psychiatric Evaluation of Adults.  Third edition.  Arlington (VA): American Psychiatric Association.  164 pages.  **URL:**  <https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760> |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | **Guideline I.** Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History  **Guideline Statements**  **Statement 1.** APA recommends (1C) that the initial psychiatric evaluation of a patient include review of the patient’s mood, level of anxiety, thought content and process, and perception and cognition.  **Statement 2.** APA recommends (1C) that the initial psychiatric evaluation of a patient include review of the patient’s trauma history.  **Statement 3.** APA recommends (1C) that the initial psychiatric evaluation of a patient include review of the following aspects of the patient’s psychiatric treatment history:   * Past and current psychiatric diagnoses * Past psychiatric treatments (type, duration, and, where applicable, doses) * Adherence to past and current pharmacological and nonpharmacological psychiatric treatments * Response to past psychiatric treatments * History of psychiatric hospitalization and emergency department visits for psychiatric issues1   Assessment of psychiatric symptoms and psychiatric treatment history is by definition a core activity of an initial psychiatric evaluation. Other core activities include identifying the reason that the patient is presenting for evaluation and understanding the patient’s background, relationships, life circumstances, and strengths and vulnerabilities. Each of these elements can be affected if a patient has been exposed to trauma.  **Guideline II.** Substance Use Assessment  **Guideline Statements**  APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of 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.  **Guideline III.** Assessment of Suicide Risk  **Guideline Statements**  **Statement 1.** APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:   * Current suicidal ideas, suicide plans, and suicide intent, including active or passive thoughts of suicide or death * Prior suicidal ideas, suicide plans, and suicide attempts, including attempts that were aborted or interrupted * Prior intentional self-injury in which there was no suicide intent * Anxiety symptoms, including panic attacks * Hopelessness * Impulsivity * History of psychiatric hospitalization and emergency department visits for psychiatric issues * Current or recent substance use disorder or change in use of alcohol or other substances * 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) * Current aggressive or psychotic ideas, including thoughts of physical or sexual aggression or homicide2 * Mood, level of anxiety, thought content and process, and perception and cognition3 * Past and current psychiatric diagnoses3 * Trauma history3   **Statement 2.** APA recommends (1C) that the initial psychiatric evaluation of a patient *who reports current suicidal ideas* include assessment of the following:   * 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 * History of suicidal behaviors in biological relatives   **Statement 3.** APA recommends (1C) that the initial psychiatric evaluation of a patient *who reports prior suicide attempts* includes assessment of the details of each attempt (e.g., context, method, damage, potential lethality, intent).  **Statement 4.** APA recommends (1C) that the clinician who conducts the initial psychiatric evaluation document an estimation of the patient’s suicide risk, including factors influencing risk.  **Guideline IV.** Assessment of Risk for Aggressive Behaviors  **Guideline Statements**  **Statement 1.** APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:   * Current aggressive or psychotic ideas, including thoughts of physical or sexual aggression or homicide * Prior aggressive or psychotic ideas, including thoughts of physical or sexual aggression or homicide * Past aggressive behaviors (e.g., homicide, domestic or workplace violence, other physically or sexually aggressive threats or acts) * Legal or disciplinary consequences of past aggressive behaviors * History of psychiatric hospitalization and emergency department visits for psychiatric issues * Current or recent substance use disorder or change in use of alcohol or other substances * Presence of psychosocial stressors * Exposure to violence or aggressive behavior, including combat exposure or childhood abuse * Past or current neurological or neurocognitive disorders or symptoms   **Statement 2.** When it is determined during an initial psychiatric evaluation that the patient has aggressive ideas, APA recommends (1C) assessment of the following:   * Impulsivity, including anger management issues * Access to firearms * Specific individuals or groups toward whom homicidal or aggressive ideas or behaviors have been directed in the past or at present * History of violent behaviors in biological relatives   **Statement 3.** APA suggests (2C) that the clinician who conducts the initial psychiatric evaluation should document an estimation of risk of aggressive behavior (including homicide), including factors influencing risk.  **Guideline V**. Assessment of Cultural Factors  **Guideline Statements**  **Statement 1.** APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the patient’s need for an interpreter.  **Statement 2.** APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of cultural factors related to the patient’s social environment.  **Statement 3.** 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. |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | Each guideline statement is separately rated to indicate strength of recommendation and strength of supporting research evidence. Grades varied per guideline statements but as noted above in each statement, were either 1C or 2C. Evidence is graded with an alphabetical letter.  C: rating for the “strength of supporting research evidence.” C represents a low rating.  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. |
| Provide all other grades and definitions from the evidence grading system | * High (denoted by the letter *A*) = High confidence that the evidence reflects the true effect. Fur- ther research is very unlikely to change our confidence in the estimate of effect. * Moderate (denoted by the letter *B*) = Moderate confidence that the evidence reflects the true effect. Further research may change our confidence in the estimate of effect and may change the estimate. * Low denoted by the letter *C*) = Low confidence that the evidence reflects the true effect. Further research is likely to change our confidence in the estimate of effect and is likely to change the estimate. |
| Grade assigned to the **recommendation** with definition of the grade | Grades varied per guideline statements but as noted above in each statement, were either 1C or 2C. Recommendations are graded using a number.  1: a “recommendation” that indicates confidence that the benefits of the intervention clearly outweigh harms.  2: a “suggestion” indicates uncertainty (i.e., the balance of benefits and harms is difficult to judge, or either the benefits or the harms are unclear). |
| Provide all other grades and definitions from the recommendation grading system | In accordance with the “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.” |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | **Quantity:** An initial search of MEDLINE was conducted in October 2010. This search yielded 250,981 articles. A second set of searches was conducted in October 2011. These searches yielded 32,895 articles in MEDLINE, 7,052 articles in PsycINFO, and 5,986 articles in the Cochrane database. All searches were done for the years from 1900 to the time of the search.  A total of 5,073 articles met the broad inclusion criteria. The total number of studies that were agreed to have relevance to the PICOTS question for each guideline topic is as follows: 0 studies for Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History; 4 studies for Substance Use Assessment; 1 study for Assessment of Suicide Risk; 2 studies for Assessment of Risk for Aggressive Behaviors; 0 studies for Assessment of Cultural Factors; 3 studies for Assessment of Medical Health; 2 studies for Quantitative Assessment; 17 studies for Involvement of the Patient in Treatment Decision Making; and 0 studies for Documentation of the Psychiatric Evaluation.  **Quality:** Included articles were those that pertained to a clinical trial (including a controlled or randomized trial), observational study, meta-analysis, or systematic review and were clinically relevant to psychiatric evaluation (i.e., relevant to any possible clinical question that might be addressed by potential APA practice guidelines). Excluded references included articles on nosology of psychiatric disorders, risk factors or associated features of specific dis- orders, potential etiologies of specific disorders, and course and prognosis of specific disorders. |
| Estimates of benefit and consistency across studies | **Benefits:** The focus of the measure is to evaluate all psychiatric inpatients to determine whether admission screenings are completed for violence risk to self and others, substance use, psychological trauma history and patient strengths. The benefit is the improvement in 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. This information assessed during the initial psychiatric evaluation contributes in determination of an appropriate treatment plan.  **Consistency:** Research on psychiatric assessment is 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 related to 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. Despite the difficulties in obtaining quantitative evidence from randomized trials, the body of evidence supports the initial screening of the psychiatric patient. |
| What harms were identified? | Potential harms of assessment were not a focus of the study but were determined to be minimal. Potential harms considered could include spending too much time on one assessment domain which may result in reducing time available to assess/document other, potentially more important findings of an evaluation. |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | An update of the literature search was conducted in September 2014 using the same databases and search strategies used for the October 2011 search. These searches in September 2014 yielded 8,521 additional articles in MEDLINE, 1,980 additional articles in PsycINFO, and 1,310 additional articles in the Cochrane database. After duplicates were eliminated, 11,644 abstracts were screened for relevance by two individuals (L.F., J.Y.). A total of 65 additional references met the broad inclusion criteria, and of these, 1 study was relevant to Quantitative Assessment. |

**From previous submission:**

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| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | **Title:** Practice Guideline for the Psychiatric Evaluation of Adults Second Edition  **Author:** American Psychiatric Association Work Group on Psychiatric Evaluation  **Date:** June 2006  **Citation, including page number:** 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]  **URL**: <https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/psychevaladults.pdf>  National Guideline Clearinghouse:  http://www.guideline.gov/content.aspx?id=9317&search=psychiatric+evaluation  **Rationale for Using this Guideline Over Others:** APA began developing practice guidelines in 1991. The development process is detailed in a document available from the APA Department of Quality Improvement and Psychiatric Services, the "APA Guideline Development Process." Key features of this process include the following:  • A comprehensive literature review  • Development of evidence tables  • Initial drafting of the guideline by a work group that included psychiatrists with clinical and research expertise in psychiatric evaluation  • Production of multiple revised drafts with widespread review  • Approval by the APA Assembly and Board of Trustees  • Planned revisions at regular intervals  This guideline represents a synthesis of current scientific knowledge and rational clinical practice on the psychiatric evaluation of adults. It strives to be as free as possible of bias toward any theoretical approach. |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | Domains of the Clinical Evaluation  General psychiatric evaluations involve a systematic consideration of the broad domains described in this guideline and vary in scope and intensity. Table 1 summarizes the domains. The intensity with which each domain is assessed depends on the purpose of the evaluation and the clinical situation. An evaluation of lesser scope may be appropriate when its purpose is to answer a circumscribed question. Such an evaluation may involve a particularly intense assessment of one or more domains especially relevant to the reason for the evaluation.  Across all domains, evaluations are generally based on three sources of information: 1) observation and interview of the patient; 2) information from others (e.g., family, significant others, case managers, other clinicians [including the patient´s primary care physician]) that corroborates, refutes, or elaborates on the patient´s report; and 3) medical records. An awareness of how people report current symptoms and events is important to the clinical assessment process. In considering the information obtained, the patient´s current mental state is relevant. Mistakes in comprehension, recall, and expression may also lead to erroneous reporting of information (F).  A. Reason for the Evaluation  The purpose of the evaluation influences the focus of the examination and the form of documentation. The reason for the evaluation usually includes (but may not be limited to) the chief complaint of the patient. It should be elicited in sufficient detail, including the patient´s words, to permit an understanding of the duration of the complaint and the patient´s specific goals for the evaluation. If the symptoms are of long standing, the reason for seeking treatment at this specific time is relevant; if the evaluation was occasioned by a hospitalization, the reason for the hospitalization is also relevant. If the patient did not initiate the evaluation, the reason another individual or entity may have requested or required it should be noted. The opinions of other parties, including family, can also assist in establishing a reason for evaluation. Under some circumstances (e.g., with psychotic or uncommunicative patients), input from others may be crucial.  B. History of the Present Illness  The history of the present problem or illness is a chronologically organized history of recent exacerbations or remissions and current symptoms or syndromes. These may involve descriptions of worries, changes in mood, suspicions, preoccupations, delusions, or hallucinatory experiences as well as recent changes in sleep, appetite, libido, concentration, memory, or behavior, including suicidal or aggressive behaviors. Information gathered on the pertinent positive and pertinent negative features of the history of present illness will vary with the patient´s presenting symptoms or syndrome. Temporal features relating to the onset or exacerbation of symptoms may also be relevant (e.g., onset after use of exogenous hormones, herbal products, or licit or illicit substances; variation in symptoms with the menstrual cycle; postpartum onset). Also pertinent are factors that the patient and other informants believe to be precipitating, aggravating, or otherwise modifying the illness. Available details of previous treatments and the patient´s response to those treatments will be delineated as part of the history of present illness. If the patient was or is in treatment with another clinician, the effects of that relationship on the current illness, including transference and countertransference issues, are considered. Input from members of a clinical team who care for the patient can be very helpful (Section IV.A.6). For patients seen on medical-surgical units, it is important to consider the history of both the present medical-surgical illness and the present psychiatric illness (G).  C. Past Psychiatric History  The past psychiatric history includes a chronological summary of all past episodes of mental illness, including substance use disorders, and treatment. The summary includes prior hospitalizations; suicide attempts, aborted suicide attempts, or other self-destructive behavior; psychiatric syndromes not formally diagnosed at the time; previously established diagnoses; treatments offered; and responses to and satisfaction with treatment. With respect to psychotherapy, it is important to ascertain the type (e.g., psychodynamic, cognitive, behavioral, supportive), format (e.g., group, individual, couple), frequency, duration, patient´s perception of the alliance, and adherence. With respect to medications, the dose, efficacy, side effects, treatment duration, and adherence are important to ascertain while understanding that reporting errors are more likely to occur when treatment involved more than one medication (G). With respect to other somatic therapies such as electroconvulsive therapy, information on the number of treatment sessions, treatment course duration, technical parameters, efficacy, and side effects is similarly useful to obtain. When past medical records are available and readily accessible, it is important that they be consulted for ancillary information.  The chronological summary also delineates the most recent periods of stability as well as episodes when the patient was functionally impaired or seriously distressed by mental or behavioral symptoms, even if no formal treatment occurred. Such episodes frequently can be identified by asking the patient about the past use of psychotropic medications prescribed by other clinicians and otherwise unexplained episodes of social or occupational disability.  D. History of Substance Use  The psychoactive substance use history includes past and present use of both licit and illicit psychoactive substances, including but not limited to alcohol, caffeine, nicotine, marijuana, cocaine, opiates, sedative-hypnotic agents, stimulants, solvents, MDMA (methylenedioxymethamphetamine), androgenic steroids, and hallucinogens (G). Relevant information includes the quantity and frequency of use and route of administration; the pattern of use (e.g., episodic versus continual, solitary versus social); functional, interpersonal, or legal consequences of use; tolerance and withdrawal phenomena; any temporal association between substance use and other present psychiatric illnesses; and any self-perceived benefits of use. It is also important to inquire about prior treatments for substance use disorders as well as about periods of abstinence, including their duration, recentness, and factors that aided in sobriety or contributed to relapse. Obtaining an accurate substance use history often involves a gradual, nonconfrontational approach to inquiry that involves asking multiple questions to seek the same information in different ways and using slang terms for drugs, patterns of use, and drug effects. Patients are particularly likely to underestimate their level of substance abuse and their related functional impairments; corroboration by other family members is useful when possible. It is also helpful to inquire about patterns of substance use by others within the family or living constellation. For more extensive discussion of the assessment of substance use, abuse, and dependence, the reader is referred to the Center for Substance Abuse Treatment´s Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse (G) and APA´s Practice Guideline for the Treatment of Patients With Substance Use Disorders (G).  E. General Medical History  The general medical history includes available information on known general medical illnesses (e.g., hospitalizations, procedures, treatments, and medications), allergies or drug sensitivities, and undiagnosed health problems that have caused the patient major distress or functional impairment. This includes history of any episodes of important physical injury or trauma; sexual and reproductive history; and any history of endocrinological, infectious (including but not limited to HIV, tuberculosis, and hepatitis C) (G), neurological disorders, sleep disorders (including sleep apnea), and conditions causing pain and discomfort. Of particular importance is a specific history regarding diseases and symptoms of diseases that have a high prevalence among individuals with the patient´s demographic characteristics and background—for example, infectious diseases in users of intravenous drugs or pulmonary and cardiovascular disease in people who smoke. Information regarding all current and recent medications, including hormones (e.g., birth control pills, androgens), over-the-counter medications, herbal supplements, vitamins, complementary and alternative medical treatments, and medication side effects, is part of the general medical history. With all aspects of the general medical history, obtaining corroborating information (e.g., from medical records, treating clinicians, family) can be helpful, since ordinary errors in comprehension, recall, and expression can lead to errors in patient reports (F).  F. Developmental, Psychosocial, and Sociocultural History  The personal history reviews the stages of the patient´s life, with special attention to perinatal events, delays in physical or psychological development, formal educational history, academic performance, and patterns of response to normal life transitions and major life events, including parental loss or divorce; physical, emotional, or sexual abuse; and other trauma such as exposure to political repression, war, or a natural disaster (G). The childhood and adolescent history of risk factors for later psychiatric disorders (Table 2) may also be relevant. History of adaptive skills and strengths to overcome challenges is also relevant.  The patient´s capacity to maintain stable and gratifying interpersonal relationships should be noted, including the patient´s capacities for attachment, trust, and intimacy. A sexual history is obtained and includes consideration of sexual orientation and practices, past sexual experiences (including unwanted experiences), and cultural beliefs about sex (G). The psychosocial history also determines the patient´s past and present levels of interpersonal functioning in family and social roles (e.g., marriage, parenting) (C, F and C). This includes a delineation of the patient´s history of marital and other significant relationships. For patients with children (including biological, foster, adopted, or stepchildren), the psychosocial history will include information about these individuals and their relationship to the patient.  As part of the psychosocial history, past or current stressors are assessed and include the categories on axis IV of DSM-IV-TR: primary support group, social environment (e.g., discrimination and acculturation), education, occupation, housing, economic status, and access to health care. Specific information obtained in evaluating psychosocial stressors may include details about patients´ living arrangements, access to transportation, sources of income, insurance or prescription coverage, and past or current involvement with social agencies. Assessment of the patient´s self-care functioning may also include consideration of exercise behavior and money management skills, including gambling behavior.  The sociocultural history delineates the patient´s migration history and past and current sociocultural context of supports and stressors as well as other important cultural and religious influences on the patient´s life (G). Emphasis is given to relationships, both familial and nonfamilial, and to religion and spirituality that may give meaning and purpose to the patient´s life and provide support, as described in the DSM-IV-TR Outline for Cultural Formulation (described in more detail in Section IV.B.1.a).  Patients present for a psychiatric evaluation with their own interests, preferences, and value systems pertaining to health care practice, and these are another important part of the sociocultural history. They may involve cultural factors and explanatory models of illness that affect attitudes, expectations, and preferences for professional and popular treatments, as described in the DSM-IV-TR Outline for Cultural Formulation and the 2004 Core Competencies of the American Board of Psychiatry and Neurology (G). Also important to the assessment and treatment process are other domains such as existential, moral, and interpersonal values and social influences such as school, church, work, and community or other agencies. Attending to these factors plays a crucial role in developing a therapeutic alliance, negotiating a treatment plan, determining the outcome criteria for successful treatment, and enhancing treatment adherence. Belief systems may also influence the handling of privacy and confidentiality during the evaluation as well as influence the type and amount of information disclosed as part of any informed consent process. In addition, patients´ value systems are relevant to clinical considerations at important life transitions (e.g., job and career transitions, marital transitions, genetic counseling before or during pregnancy, end-of-life planning).  G. Occupational and Military History  The occupational history describes the sequence and duration of jobs held by the patient, reasons for job changes, and the patient´s current or most recent employment, including quality of work relationships and whether current or recent jobs have involved shift work, a noxious or perilous environment, exposure to hazardous materials, unusual physical or psychological stress, or injury or exposure to trauma while in the military or hazardous occupations (e.g., fire and rescue, law enforcement). Work skills and strengths are noted, as well as the quality of the patient´s relationships with co-workers and work supervisors. Past or current experience with the workers´ compensation system and patterns of recovery or disability following episodes of illness are also determined (G, F, B and. B). When appropriate, a history of preparation for and adjustment to retirement is included.  Relevant data about military experience include volunteer, recruited, or draftee status; reasons for rejection at time of enlistment (if relevant); combat exposure (if any); awards; disciplinary actions; and discharge status.  H. Legal History  The legal history includes a description of past or current involvement with the legal system (G). This may include interactions with the police without formal arrest as well as involvement with the juvenile or criminal justice system (e.g., arrests, detentions including jail or prison confinement). Individuals may be on probation or parole or may have pending court appearances or active warrants for arrest that will influence treatment planning. A history of legal problems relating to aggressive behaviors or occurring in the context of substance intoxication is similarly relevant. Other past or current interactions with the court system (e.g., family court, workers´ compensation, civil litigation, court-ordered psychiatric treatment) may serve as significant stressors for the patient and are also important to address (G). |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | **System Used for Grading the Body of Evidence:** Other  **If other, identify and describe the grading scale with definitions:** Although grading of the evidence was not determined during the systematic review, it was determined that the guideline developers accounted for a balanced representation of information, looked beyond one specialty group or discipline, and provided information that was accessible and met the requirements set out in the NQF criteria.  **Grade Assigned to the Body of Evidence:** Not Applicable |
| Provide all other grades and definitions from the evidence grading system | Not Applicable |
| Grade assigned to the **recommendation** with definition of the grade | **If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:** American Psychiatric Association  **Grade Assigned to the Recommendation:** Varies by domain |
| Provide all other grades and definitions from the recommendation grading system | **System Used for Grading the Strength of Guideline Recommendation:** Other  **If other, identify and describe the grading scale with definitions:** The evidence base for these 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. |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | **Directness of Evidence to the Specified Measure**  This measure is consistent with the guidelines recommended by the American Psychiatric Association (APA) to include screening for violence risk to self and others, substance use, psychological trauma history and patient strengths during the psychiatric evaluation. These risk factors have been identified to have a high degree of co-occurrence in psychiatric inpatients. The focus of both the performance measure and the body of evidence supports the need for admission screening for violence risk to self and others, substance use, psychological trauma history and patient strengths.  **Quantity:**  Relevant literature supporting psychiatric screening was identified by the American Psychiatric Association 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.  **Quality:**  The quality of evidence supporting the value of screening patients for violence risk to self and others, substance use, psychological trauma history and patient strengths completed is moderate. It is noteworthy to examine the fact that randomized control trials cannot be conducted, as one cannot randomly select patients who receive the screening and those who do not given the serious consequences of under detection and treatment of violence risk to self and others, substance use, psychological trauma history and patient strengths.  As noted above, the American Psychiatric Association has had guidelines in place since 1995 addressing the key aspects of a psychiatric evaluation which include screening for violence risk to self and others, substance use, psychological trauma history and patient strengths. In spite of the fact that all studies reviewed were either retrospective or prospective cohort studies, no study design flaws were noted.  **Summary of Controversy/Contradictory Evidence:** There is no documented evidence regarding controversy related to admission screening for violence risk to self and others, substance use, psychological trauma history and patient strengths. A review of recent studies also supports the use of quality improvement interventions to further increase compliance with the admission screening for violence risk to self and others, substance use, psychological trauma history and patient strengths. No position against the importance to screen for risk of violence to self or others, substance use, psychological trauma history and patient strengths was identified in the literature.  **Based on the NQF descriptions for rating the evidence, what was the developer’s assessment of the quantity, quality, and consistency of the body of evidence?**  **1c.25** Quantity:High  **1c.26** Quality:Moderate  **1c.27** Consistency**:** High |
| Estimates of benefit and consistency across studies | **Benefit:**  The initial screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths is to assist the clinician in determining which patients require a more in depth assessment based on findings which will ultimately form the basis for an appropriate treatment plan. The resultant reduction in the under-detection of violence risk, SUD and trauma history will in turn decrease the chance of psychiatric relapse and lead to improved medication compliance which will ultimately result in substantial savings in health care costs. Focusing on patient strengths instead of problems during the screening process will also empower the patient to embrace the ongoing recovery model of treatment. No harms to the patient receiving an initial screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths was found during the literature review.  **Consistency:**  The body of evidence consistently supports the benefit of routine initial screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths. Initial admission screening is consistently mentioned as an important step that is necessary to perform in order to develop the appropriate treatment plan in studies on risk of violence to self or others, substance use, psychological trauma history and patient strengths. No position against the importance to screen for risk of violence to self or others, substance use, psychological trauma history and patient strengths was identified in the literature. |
| What harms were identified? | No harms to the patient receiving an initial screening for risk of violence to self or others, substance use, psychological trauma history and patient strengths was found during the literature review. |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | An updated 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 references) 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. |

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**1a.4 OTHER SOURCE OF EVIDENCE**

*If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.*

**1a.4.1** **Briefly SYNTHESIZE the evidence that supports the measure.** A list of references without a summary is not acceptable.

Not applicable for this submission

**1a.4.2 What process was used to identify the evidence?**

Not applicable for this submission

**1a.4.3.** **Provide the citation(s) for the evidence.**

Not applicable for this submission

**From previous submission: Citations for Evidence other than Guidelines**

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