

Introduction to Mental Health Assessment

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Designed as a quick-reference guide for students, clinicians, and anyone interested in the basics of mental health evaluation.

1. What Is a Mental Health Assessment?

Aspect	Description
Definition	A systematic process of gathering information to understand a person's emotional, cognitive, and behavioral functioning.
Purpose	• Identify psychiatric diagnoses • Determine severity & functional impact • Guide treatment planning • Monitor progress over time
Setting	Outpatient clinic, primary care office, emergency department, community agency, telehealth, or inpatient unit. • Confidentiality – HIPAA/local privacy laws
Key Principles	• Cultural competence – respect language, beliefs, and values • Trauma-informed – assume safety, choice, collaboration • Strength-based – focus on resilience and resources

2. Core Components of the Assessment

Component	What It Covers	Typical Tools / Methods
1. Identifying Information	Demographics, contact details, legal status, emergency contacts.	Intake forms, electronic health record (EHR).
2. Presenting Problem	Chief complaint, duration, triggers, impact on daily life.	Open-ended interview, symptom checklist.
3. Psychiatric History	Past diagnoses, hospitalizations, treatments, medication trials, suicide attempts.	Structured interview (e.g., SCID-5), timeline graphic.
4. Medical & Developmental History	Chronic illnesses, surgeries, birth history, developmental milestones.	Medical record review, patient/family interview.

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5. Substance Use	Alcohol, nicotine, illicit drugs, prescription misuse.	AUDIT, DAST-10, CAGE questionnaire.
6. Family & Social History	Family psychiatric history, relationships, support network, housing, employment, education.	Genogram, social history questionnaire.
7. Mental Status Examination (MSE)	Appearance, behavior, speech, mood/affect, thought process, thought content, perception, cognition, insight/judgment.	Observation + brief cognitive tests (MMSE, MoCA).
8. Risk Assessment	Suicide, homicide, self-harm, aggression, neglect, mania, psychosis.	Columbia Suicide Severity Rating Scale (C-SSRS), HCR-20.
9. Functional Assessment	Daily living skills, work/school performance, social roles.	WHODAS 2.0, GAF, SDS.
10. Strengths & Resources	Coping skills, spiritual beliefs, community ties, previous successes.	Narrative interview, resilience scales.
11. Diagnostic Formulation	Synthesis of data into DSM-5/ICD-11 diagnoses and differential list.	Clinical judgment, structured diagnostic tools.
12. Treatment Planning	Goals, interventions, referrals, follow-up schedule.	SMART goals, care coordination checklist.

3. Common Structured Interviews & Rating Scales

Tool	Target Population	Primary Use
SCID-5	Adults	Gold-standard DSM-5 diagnostic interview
MINI	Adults & adolescents	Brief, structured diagnostic screen
C-SSRS	All ages	Suicide risk severity
PHQ-9	Adults	Depression severity
GAD-7	Adults	Anxiety severity
AUDIT	Adults	