

What is a Mental health assessment?

It is important to be aware of the procedures in your workplace for accessing specialist mental health assessments for your patients. Many hospital settings have access to a consultation-liaison service or mental health clinicians who can complete a mental health assessment.

In Queensland Health, a mental health assessment can be completed by a psychiatrist, psychiatric registrar or clinician (psychologist, social worker, occupational therapist, mental health nurse) within the mental health service. A comprehensive mental health assessment will involve clinical assessment and information gathering in the following areas:

- ◆ Presenting problems
- ◆ History of presenting problems (onset, duration, course, severity)
- ◆ Current functioning (across domains for example, employment/education, family, social)
- ◆ Relevant cultural issues (personal and family)
- ◆ Previous assessments and interventions*
- ◆ Psychiatric history (personal and family history)
- ◆ Current medications
- ◆ Medical history
- ◆ Family history
- ◆ Developmental history**
- ◆ Substance use
- ◆ Forensic and legal history
- ◆ Risk screen (for example, suicide, self-harm, aggression, vulnerability; absconding risk⁺, risks to dependent children⁺⁺, and risk of disrupted attachment⁺⁺⁺)
- ◆ Goals for treatment
- ◆ Mental Status Examination

* Standardised assessments may also form part of a comprehensive mental health assessment. This may include cognitive and psychometric assessments.

** Included in assessment of children and young people.

+ For inpatient consumers.

++ For consumers who have care/custody responsibilities for children (full-time or periodic).

+++ For children and young people

A core part of a comprehensive mental health assessment is the clinical formulation. This is a clinical summary of the assessment using a bio-psycho-social approach. The clinical formulation broadly aims to answer the questions ‘why this person?’, ‘why this problem?’, ‘why at this time?’. The formulation will include information regarding the predisposing, precipitating, perpetuating and protective factors that are relevant to the person’s clinical presentation, the diagnosis, the prognosis and current risks.

Following the completion of the comprehensive mental health assessment, a treatment plan is developed. A standard treatment plan includes recommended actions to reduce and/or manage risk, recommendations regarding the need for follow up assessment/treatment and an outline of treatment objectives.