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Mental Health Assessment

Mental Health Nursing

Psychiatric history, mental status examination (MSE), physical assessment, psychological assessment, diagnostic investigations, risk assessment and nursing documentation.

For educational purposes only.

CHAPTER 03 / MENTAL HEALTH NURSING 03. Mental Health Assessment

1. Psychiatric history

Introduce role, explain purpose and confidentiality limits, obtain consent, ensure privacy. Record identifying information and source/reliability; chief concerns in patient's own words, onset/course/triggers, past psychiatric and medical/surgical history, medications, substance use, allergies, family and personal developmental history, education, work, relationships, trauma only as clinically appropriate, strengths, supports and baseline functioning. Obtain collateral information with appropriate consent or lawful basis.

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2. Mental status examination (MSE)

MSE is a structured description of current mental functioning. It is time-specific and distinct from history.

Domain	What to assess
Appearance and behaviour	Grooming, posture, eye contact, psychomotor activity, cooperation, movements.
Speech	Rate, volume, fluency, amount, latency and coherence.
Mood and affect	Mood is subjective emotional state; affect is observed expression, range/reactivity and congruence.
Thought form	Goal direction, tangentiality, circumstantiality, flight of ideas, loosening, blocking.
Thought content	Delusions, obsessions, preoccupations, hopelessness, self-harm or harm-to-others thoughts.
Perception	Hallucinations, illusions, depersonalization/derealization.
Cognition	Alertness, orientation, attention, memory, language and executive function as indicated.
Insight and judgment	Understanding of difficulties and ability to evaluate consequences; avoid absolute labels.

3. Physical, psychological and diagnostic assessment

Vital signs, physical/neuro examination, medication adverse effects, sleep, nutrition, pain, elimination and functional status. CBC, electrolytes, glucose, thyroid/renal/liver tests, toxicology, ECG, imaging/EEG or infection tests as clinically indicated. PHQ-9, GAD-7, MMSE/MoCA or other validated tools support screening/monitoring, not standalone diagnosis; follow training and permissions.

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4. Risk assessment

Ask directly and sensitively about suicidal thoughts, intent, plan, access to means, past attempts, recent losses, supports and reasons for living. Assess violence risk using specific behaviour/history, intoxication and immediate threats, not diagnosis alone. Assess self-neglect, vulnerability, abuse, withdrawal, delirium, falls and medication toxicity. Risk is dynamic; formulate current needs, protective factors, safety plan and level of observation, review after changes. Do not use a score alone to determine discharge or predict suicide.

5. Documentation example

Patient states "I have slept only two hours each night." Speech rapid, frequently interrupts, attention easily diverted; orientation to person/place/time intact. Record relevant exact statements, observations, time, action and referrals without speculating about motives. Report new confusion, severe agitation, suicidal intent or altered consciousness promptly.

6. Important Examination Questions

Long Answer Questions

1. 1. Define MSE and explain its domains, psychiatric history and risk assessment.

Short Answer Questions

1. 1. Differentiate mood/affect, thought form/content and hallucination/illusion
2. 2. describe investigations.

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Very Short Answer Questions (with answers)

1. 1. What does MSE stand for? - Mental status examination.
2. 2. Is MSE a lifetime history? - No.

7. Quick Revision

- History and MSE complement each other.
- Assess medical mimics.
- Record objective findings and dynamic risk.

8. Conclusion

History and MSE complement each other. Assess medical mimics. Record objective findings and dynamic risk.

Practice questions

Choose one best answer. The answer key and explanations follow the questions.

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1. Which finding belongs under affect rather than mood in the mental status examination?

A. The patient's reported emotional state

B. The patient's medication history

C. The sequence of symptoms over several years

D. Observed emotional expression and range

2. Which description best distinguishes the mental status examination from psychiatric history?

A. It describes current mental functioning at a particular time.

B. It is a complete lifetime account of mental illness.

C. It records only previous admissions and treatments.

D. It replaces the need for a psychiatric history.

3. How should a nurse use a validated screening tool such as PHQ-9 during assessment?

A. As a standalone diagnosis

B. As support for screening or monitoring alongside assessment

C. As the sole basis for discharge

D. As a substitute for physical assessment

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Answer key and explanations

1. D - Observed emotional expression and range

Affect concerns observed expression; mood is the subjective emotional state.

2. A - It describes current mental functioning at a particular time.

The MSE is a time-specific account of current functioning.

3. B - As support for screening or monitoring alongside assessment

Validated tools support screening and monitoring but do not establish a diagnosis by themselves.

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