Mental Health Assessment Skills

Chapter 9

Learning Objectives
Lesson 9.1: Mental Health Assessment Skills

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1. Identify two purposes of the mental health treatment plan.
2. List and define each step of the nursing process.
3. Describe three methods of data collection.
4. List six parts of a holistic nursing assessment.
5. Identify four guidelines for conducting effective psychiatric interviews.

Learning Objectives
Lesson 9.1: Mental Health Assessment Skills

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6. Explain the importance of performing physical assessments of clients with psychiatric diagnoses.
7. Explain the purpose of the mental status examination.
8. List the five general categories of the mental status examination.
9. Describe the process for conducting a mental status examination.

Mental Health Treatment Plan

(Slide 1 of 5)

- Every psychological problem has physical effects, and each physical illness has psychological effects
  - The wise care provider is aware of both
- Individuals entering into the mental health care system undergo a comprehensive assessment
- Clients are interviewed by several members of the multidisciplinary health care team

Mental Health Treatment Plan

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- Physician
  - Provides information regarding a client's physical state and the need for medications
- Social worker
  - Assesses the client's family, work, and social interactions
- Dietitian
  - Learns about the client's nutritional status

Mental Health Treatment Plan

(Slide 3 of 5)

- Psychiatrist and psychologist
  - Explore the client's emotional and cognitive (intellectual) functioning
- Nurse
  - Assesses how the illness or disability affects the client's activities of daily living
- Other care providers
  - Contribute information through their observations and interactions with the client

Mental Health Treatment Plan

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- When the team and the client agree on the treatment goals, a course of action is planned
- Medical treatments (medications) are combined with psychotherapies, behavioral therapies, and other therapeutic actions
- Treatment plans are developed especially for the individual client

Mental Health Treatment Plan

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- Purposes of the mental health treatment plan
  - Acts as a guide for planning and implementing client care
  - Serves as a vehicle for monitoring the client's progress and the effectiveness of therapeutic interventions
  - Serves as a means for communicating and coordinating client care

DSM-5 Diagnosis

- *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* is a tool that is used to facilitate diagnosis and guide clinical practice
  - Clients are assessed and classified according to five categories
  - This system helps care providers gain a more complete understanding of each person

Nursing (Therapeutic) Process

(Slide 1 of 4)

- Designed to support goal-directed care for clients
- Serves as an organizational framework for effective care
- Consists of five steps
  - Assessment
  - Diagnosis
  - Planning
  - Intervention
  - Evaluation
- Encourages us to focus on the client and develop appropriate and effective care measures

Nursing (Therapeutic) Process

(Slide 2 of 4)

- Assessment
  - Data are collected
- Diagnosis
  - Data are sorted into related areas, and problems are identified
  - Each problem then is examined in detail
- Planning
  - "Expected outcomes" then are used to monitor the client's progress

Nursing (Therapeutic) Process

(Slide 3 of 4)

- Intervention
  - Planned actions are implemented
  - Actions are carried out by all mental health care team members
  - Therapeutic actions guide clients toward their goals
- Evaluation
  - Effectiveness of care is determined

Nursing (Therapeutic) Process

(Slide 4 of 4)

- Clients are involved as partners in care
- Caregivers help clients problem-solve by involving them in the care planning process
- The art of choosing the best course of action must be practiced carefully
- Let the “do no harm” principle guide you as you grow

Assessment

- Assessment
  - The “gathering, verifying and communicating of information relative to the client”
- Holistic assessment includes gathering information regarding physical, intellectual, social, cultural, and spiritual aspects of each client

Data Collection

- Data are grouped into objective and subjective categories
- *Objective data* refers to information that can be measured and shared
  - Gathered through the senses of sight, smell, touch, and hearing
- *Subjective data* relates to clients' perceptions
  - The experiences of pain, nausea, and anxiety cannot be measured by anyone other than the individual who is experiencing them

Data Collection Methods

- Data collection methods for care providers include the following:
  - Interview
    - A meeting of persons for the purpose of obtaining or exchanging information
  - Observational techniques
    - Process of purposeful looking
  - Rating scales and inventories
    - Data-gathering tools specifically designed to bring out certain types of information

Assessment Process

- The psychiatric assessment tool focuses on obtaining data about the problems, coping behaviors, and resources of clients
- Risk factor assessment
  - Required for clients who may pose a risk for violence toward themselves or others
  - Helps “formulate a nursing diagnosis based on the identification of risk factors that potentially present an immediate threat to the patient”
  - Completed by a registered nurse

The Health History

(Slide 1 of 3)

- Effective interviews
  - Success of any client interview rests on the caregiver's ability to listen objectively and respond appropriately
  - Guidelines for an effective interview include:
    - Personal values must not cloud professional judgments
    - Make no assumptions
    - Take into account the client's cultural and religious values and beliefs
    - Pay attention to nonverbal communications
    - Have clearly set goals
    - Monitor your own reactions

The Health History

(Slide 2 of 3)

- Sociocultural assessment
  - Concentrates on the cultural, social, and spiritual aspects of an individual
  - Focuses on six areas
    - Age
    - Ethnicity (culture)
    - Gender
    - Education
    - Income
    - Belief system
- Risk factors and stressors also are defined during the sociocultural assessment

The Health History

(Slide 3 of 3)

- Review of each body system and its functioning
  - Clients are questioned about the following:
    - General health care
    - Past illnesses
    - Hospitalizations
    - Family health history
  - Questions then focus on the function of each body system
- The lifestyle and activities of daily living also are assessed

Physical Assessment

- Performed to discover physical problems that can be treated medically
- A complete physical examination is performed by a physician or a nurse practitioner
  - Not needed every day
- Diagnostic studies include the following:
  - Standard blood tests
  - Urine tests
  - Hormone function tests
  - Human immunodeficiency virus (HIV) and tuberculosis (TB)
  - X-ray, positron emission tomography (PET), and magnetic resonance imaging (MRI)
  - Electrocardiograms (ECGs)

Mental Status Examination

- Allows care providers to observe and describe a client's behavior in an objective, nonjudgmental way
- Understanding each part of the examination enables care providers to plan and deliver the most appropriate care for each client

Mental Status Assessment

- Explores the following areas:
  - General description
  - Emotional state
  - Experiences
  - Thinking
  - Sensorium and cognition

General Description

- Client is assessed for the following:
  - General appearance
  - Speech
  - Motor activity
  - Behavior during the interaction
- All findings are documented

Emotional State

- To assess the client's emotional state, the care provider considers the client's mood and affect
- Document objective descriptions of the client's behaviors
- Descriptions communicate much more information than is conveyed by a single medical term

Experiences

- Experience assessments explore the client's perceptions, which is the way that he or she experiences the world
- An individual's perceptions often are called his or her *frame of reference.*
- A person's perceptions help determine his or her sense of reality

Thinking

- Thought content relates to what an individual is thinking
- Clients may experience the following:
  - Delusions
  - Obsessions
  - Phobias
  - Preoccupations
  - Amnesia
  - Confabulations

Sensorium and Cognition

- Sensorium is that part of the consciousness that perceives, sorts, and combines information
- People with a clear sensorium are oriented to time, place, and person
- In this category, patients are assessed for:
  - Memory
  - Calculation
  - Judgment
  - Education level
  - Insight

Questions?