Ministry of Higher Education

& Scientific Research

University of Mosul
College of Nursing

Psychiatric and Mental Health Nursing

Practical Curriculum

Undergraduate Studies

BSc. in Nursing Sciences / Fourth Stage

2024 - 2025

Mental Health Status Assessment

1.General Information:			
Pt. No.:		DoA	
Name		Place and Date of Birth	
Gender		Marital Status	
Age		Address:	
Race/culture		Religious:	
Occupational/ financial status		Allergies:	
Educational level		Special diet considerations	

2.Chief complaint:	Ask the pt. or relative about the reasons for admission and referral.
3. Medical diagnosis:	If present

4. History of present illness:	
• Full history in patient own words.	
• What is the reasons and trigger?	
• How long that the patient suffer?	
• What are the participated factors?	
5. Family history:	
• Is there any psychiatric illness in the family history?	
• Ask about patient's parents' relationship, educational level and social status.	
6. Past history:	
• Medical history (physical history) especially CNS diseases.	

• Surgical history.	
• Mental illness history.	
• School history (school records).	
7. General Examination:	
A. Physical conditions: especially the CNS, allergies.	
B. Nervous habits: (e.g. bed-wetting, night terrors, sleep walking, nail biting, breath holding).	
C. Personality before illness:	
• Social relations (social and friends meeting and activity).	
• Intellectual activities (books, pictures and leisure).	
• Mood: (cheerful, desponded, optimistic, pessimistic, etc).	
• Attitude to self: (sensitive, jealous, selfish, etc.)	
• Habits: (eating, sleep, tobacco, alcohol, drug, etc).	
8. Appearance:	
• Grooming and dress	
• Hygiene	
• Posture	
• Height and weight	
• Level of eye contact	
• Hair color and texture	
• Evidence of scars, tattoos, or other distinguishing skin marks	
• Evaluation of client's appearance compared with chronological age	

9. Motor Activity:	
• Tremors	
• Tics or other stereotypical movements	
• Mannerisms and gestures	
• Hyperactivity	
• Aggressiveness	
• Rigidity or agitation	
• Gait patterns	
• Echopraxia	
• Psychomotor retardation	
• Freedom of movement (range of motion)	
10. Speech Patterns:	
• Slowness or rapidity of speech	
• Pressure of speech	
• Intonation	
• Volume	
• Stuttering or other speech impairments	
• Aphasia	
11. General Attitude:	
Cooperative/uncooperative	
Friendly/hostile/defensive	
Uninterested/apathetic	
Attentive/interested	
Guarded/suspicious	

12. Emotions: (Mood)			
1. Sad		**6.** Elated	
2. Depressed		**7.** Euphoric	
3. Despairing		**8.** Fearful	
4. Irritable		**9.** Guilty	
5. Anxious		**10.** Labile	

13. Affect:	
• Congruence with mood	
• Constricted or blunted (diminished amount/range and intensity of emotional expression.	
• Flat absence of emotional expression.	
• Appropriate or inappropriate (defines congruence of affect with the situation or with the client's behavior.	

14. Thought Processes: (Form of Thought)/ stream dis			
Flight of ideas		Word salad	
Associative looseness		Perseveration	
Circumstantiality		Echolalia	
Tangentiality		Mutism	
Neologisms		Poverty of speech	
Concrete thinking		Ability to concentrate	
Clang associations		Attention span	

15. Content of Thought:	
a. Delusions	
• Persecutory	
• Grandiose	
• Reference	
• Control or influence	
• Somatic	
• Nihilistic	
b. Suicidal or homicidal ideas	
c. Obsessions	
d. Paranoia/suspiciousness	
e. Magical thinking	
f. Religiosity	
g. Phobias	
h. Poverty of content (vague, meaningless responses)	

16. Perceptual Disturbances:		
a. Hallucinations	a. Auditory	
	b. Visual	
	c. Tactile	
	d. Olfactory	
	e. Gustatory	
b. Illusions		
c. Depersonalization (altered perception of the self		
d. Derealization (altered perception of the environment)		
17. Orientation:		
• For person: (who are the persons around you?)		
• For place and time: (what is the time?, what is today?, what is the place?, where is you are now?).		
• Circumstances		
18. Attention and concentration:		
• Can the pt. count the days of week?		
• How long does the patient take to subtract serial 7 from 100, count mistakes?.		
19. Memory:		
• Immediate retention: of the names, address, telephone numbers, repetition of a series of digits forwards and backwards (ask the pt. to repeat it after 5 minutes).		
• Recent: (ask the pt. about recent events).		
• Remote: (ask the pt. about past events).		
• Confabulation		
20. Intelligence:		
• (by interview or using I.Q. scale, and school records).		
21. General Knowledge:		
• Ask the pt. about general important information, e.g. name of president, names of famous countries, places and persons, etc.).		

22. Impulse Control: Ability to control impulses related to the following:	
a. Aggression	
b. Hostility	
c. Fear	
d. Guilt	
e. Affection	
f. Sexual feelings	
23. Judgment and Insight:	
• Ability to solve problems	
• Ability to make decisions	
• Knowledge about self	
Awareness of limitations	
Awareness of consequences of actions	
Awareness of illness	
Judgment: (ask the pt. what will he do in special trigger?).	
Insight: (does the patient feel he is ill or not?, does he need the treatment or not?).	
24. Adaptive/maladaptive use of coping strategies	

Information for Data Collection

Area of Assessment	Type of of Assessmen t	Suggested Methods of Assessment and Normal Parameters	Alterations to Normal Assessment
Appearance .	Objective and subjective observations such as dress, hygiene, posture; and about the patient's actions and reactions to health-care personnel.	Clean, hair combed; clothing intact and appropriate to weather or situation. Teeth in good repair. Posture erect. Cooperates with health-care personnel.	Displays either unusual apathy or concern about appearance.
Behavior	Objective	Cooperates with health-care personnel.	Displays uncooperative, hostile, or suspicious-type behaviors toward health-care personnel
Level of Awareness	Subjective and objective assessment of the patient's degree of alertness (wakefulness).	Awareness is measured on a continuum that ranges from unconsciousness to mania. "Normal alertness" is the desired behavior. There is usually a standard guideline for helping with this assessment, but subjective observations can be documented as well, if the patient cannot stay awake for even short intervals or is overly active and has difficulty staying in one place for any period of time.	Outcome is not within normal limits if the patient is difficult to arouse and keep awake or finds it difficult to feel calm.

Orientation	The degree of patient's knowledge of self.	Orientation measures the person's ability to know who he or she is, where he or she is, and the day and time, usually within 1 or 2 days of the actual day and time. Measurement techniques are accomplished by asking the patient, "What is your name?" "Where are you right now?" and "Tell me what the day and date are." Asking "Who is the president of the United States?" is used here as well. Nurses frequently document this as "oriented ×3," but it is best to also write down the objective data on which this routine answer is based.	Abnormal results of orientation are the patient's inability to correctly answer questions pertaining to the patient or to commonly known social information.
Thinking/ Content of Thought	Subjective assessment of what the patient is thinking and the process the patient uses in thinking.	Formal testing may be undertaken by the psychologist or psychiatrist to determine the patient's general thought content and pattern. Nurses may contribute to the assessment of thought by documenting statements the patient makes regarding daily cares and routines.	Behaviors including flight of ideas, loose associations, phobias, delusions, and obsessions may become apparent. .
Memory	Subjective assessment of the mind's ability to recall previously known recent and remote (long-term) information.	Recent memory: Recall of events that are immediately past or up to within 2 weeks before the assessment. One measurement technique is to verbally list five items. After 1 minute, patient should be able to recall 4–5 of	Inability to accurately perform recent or remote recall exercises within parameters; may indicate

		those items. Continue with assessment and at 5 minutes, patient should be able to recall 3–4 of the items. Remote memory: Recall of events of the past beyond 2 weeks prior to assessment. Patients are often asked questions pertaining to where they were born, where they went to grade school, and so on.	symptoms of delirium or dementia.
Speech and Ability to Communicate	Objective and subjective assessment of aspects of patient's use of verbal and nonverbal communication.	Patient can coherently produce words appropriate to age and education. Rate of speech reflects other psychomotor activity (e.g., faster if patient is agitated). Volume is not too soft or too loud. Stuttering, repetition of words, and words that the patient "makes up" (neologisms) are also assessed. Behaviors including flight of ideas, loose associations, phobias, delusions, and obsessions may become apparent. These alterations in "normal" thought processes are defined and discussed in future chapters that relate to specific illnesses. Inability to accurately perform recent or remote recall exercises within parameters; may indicate symptoms of delirium or dementia.	Limited speech production; rate of speech is inconsistent with other psychomotor activity. Volume is not appropriate to situation (speaks at a very loud volume even when asked to speak more quietly). Stuttering, word repetition, or neologisms may indicate physical or psychological illness.

Mood and Affect	Subjective and objective assessment of the patient's stated feelings and emotions. Affect measures the outward expression of those feelings	Mood is the stated emotional condition of the patient and should fluctuate to reflect situations as they occur. Facial expression and body language (affect) should match (be congruent with) stated mood. Affect should change to fluctuate with the changes in mood.	Mood and affect do not match (e.g., facial expression does not change when stating opposite feelings).
Abstract Thinking/ Judgment	Subjective assessment of a patient's ability to make appropriate decisions about his or her situation or to understand concepts.	Give patient a "proverb" to interpret, such as "You can't teach an old dog new tricks." Patient should be able to give some sort of acceptable interpretation such as "old habits are hard to break" or "it is hard to learn something new." Or give the patient a situation to solve (judgment). For example, ask the patient what he or she would do if a small child were lost in a store. An appropriate response might be "to call the manager" or "to try to calm the child."	Patient cannot interpret the sayings in an acceptable manner. Patient cannot complete problem solving questions appropriately. The patient might answer very literally, "Dogs can't learn anything when they get old" or "I would go through the child's pockets to see if there were any phone numbers in them."
Perception	Assesses the way a person experiences reality.	All five senses are monitored for interaction with the patient's reality.	Presence of hallucinations and illusions.

ABC Form:

An ABC chart is an observational tool that allows us to record information about a particular behaviour. The aim of using an ABC chart is to better understand what the behaviour is communicating.

- The 'A' refers to the antecedent or the event that occurred before the behaviour was exhibited. This can include what the person was doing, who was there, where they were, what sights / sounds / smells / temperatures / number of people that were in the environment.
- The 'B' refers to an objective and clear description of the behaviour that occurred e.g. X threw item on the floor.
- The 'C' refers to what occurred after the behaviour or the consequence of the behaviour e.g. children moved away from X, noise levels in the room decreased. It is important to decide on one or two target behaviours to record initially.

ABC Form

A	B	C
Activating / Triggering Event Situation (Trigger may also be a feeling)	**Beliefs**	**Consequences**
• **What was happening just before I started to feel this way?** *What was he/she doing? Who was he/she with?* *Where was he/she?*	□ Thoughts and/or Images *What was going through his/her mind at that time?* □ Meanings & interpretations *What did this say or mean about him/her?* *What was the worst thing that could happen?*	□ Emotions *What did he/she feel?* □ Physical sensations *What did he/she feel in his/her body?* □ Behaviours: actions & urges *What did he/she do?* *What did he/she feel like doing?*

Care Program Approach / CPA

Mental Health Risk Assessment

Name of the client:	**DoB:**		
Date of Assessment:	**Location of assessment:**		
1. Risk of suicide or self-harm	**Present**	**Past**	**None**
Minor self-harm without significant risk to health or life			
Suicide threats or gesture			
Serious planning of suicide			
Attempted suicide			
Comments:			
2. Risk of harm to others: (including children, staff, and the public)	**Present**	**Past**	**None**
Violence towards others- any predatory behavior with potential to abuse or offend			
Aggression without violence eg. Threats, verbal aggression			
Fantasies of violence expressed			
Known to possess dangerous weapon(s) eg. combat knife			
Arson/fire setting			
Comments:			

3. Risk to self-neglect/exploitation/abuse by others:	**Present**	**Past**	**None**
Self-neglect			
Inability to recognize hazards			
Difficulties with activities of daily living			
Vulnerable/ history of exploitation or abuse (financial/ sexual/ physical) `			
Comments:			
4. Sexual risks	**Present**	**Past**	**None**
Rape, indecent or sexual assault committed			
Sexual behaviour towards children			
Non-violent sexual offences eg. inappropriate sexual behaviour			
Fantasies of engaging in any of the above expressed			
Comments:			
5. Substance/ alcohol misuse:	**Present**	**Past**	**None**
Intravenous use			
Multi-drug use, including prescribed medication			
Psychiatric risks are seriously exacerbated by abuse of drugs or alcohol			
Comments:			
6. Forensic information:			

Consider the impact of the following factors in relation to risk behaviour:	
Y / N	The client has a diagnosis or history of severe mental illness
Y / N	The client is experiencing major life stresses (consider debt, isolation, bereavement, feelings of guilt or hopelessness, physical illness)
Y / N	Client is refusing medication/ relapsing/ disengaging with mental health services
Y / N	Impaired driving
Y / N	Client is currently homeless or in major housing need
Y / N	Are there any capacity issues to consider/ impact on risk evaluation?
Comments:	

Immediate action to manage risk:

Name(s) of assessor(s): Signature of assessor(s):

Assigning Nursing Diagnoses (NANDA) to Client Behaviors

Following is a list of client behaviors and the NANDA nursing diagnoses that correspond to the behaviors and that may be used in planning care for the client exhibiting the specific behavioral symptoms:

Behaviors	NANDA Nursing Diagnoses
Aggression; hostility	Risk for injury; Risk for other-directed violence
Anorexia or refusal to eat	Imbalanced nutrition: Less than body Requirements
Anxious behavior	Anxiety (specify level)
Confusion; memory loss	Confusion, acute/chronic; Disturbed
Delusions	Disturbed thought processes
Denial of problems	Ineffective denial
Depressed mood or anger turned inward	Dysfunctional grieving
Detoxification; withdrawal from substances	Risk for injury
Difficulty making important life decision	Decisional conflict (specify)
Difficulty with interpersonal Relationships	Impaired social interaction
Disruption in capability to Perform usual responsibilities	Ineffective role performance
Dissociative behaviors (depersonalization; derealization)	Disturbed sensory perception (kinesthetic)
Expresses feelings of disgust about body or body part	Disturbed body image

Expresses lack of control over personal situation	Powerlessness
Flashbacks, nightmares, obsession with traumatic experience	Post-trauma syndrome
Hallucinations	Disturbed sensory perception (auditory; visual)
Highly critical of self or others	Low self-esteem (chronic; situational
HIV-positive; altered immunity	Ineffective protection
Inability to meet basic needs	Self-care deficit (feeding; bathing/ hygiene; dressing/grooming; toileting)
Insomnia or hypersomnia	Disturbed sleep pattern
Loose associations or flight of ideas	Impaired verbal communication
Manic hyperactivity	Risk for injury
Manipulative behavior	Ineffective coping
Multiple personalities; gender identity disturbance	Disturbed personal identity
Orgasm, problems with; lack of sexual desire	Sexual dysfunction
Overeating, compulsive	Risk for imbalanced nutrition: More than body requirements
Phobias	Fear
Physical symptoms as coping Behavior	Ineffective coping
Projection of blame; rationalization of failures; denial of personal responsibility	Defensive coping

Ritualistic behaviors	Anxiety (severe); Ineffective coping
Seductive remarks; inappropriate sexual behaviors	Impaired social interaction
Self-mutilative behaviors	Self-mutilation; Risk for self-mutilation
Sexual behaviors (difficulty, limitations, or changes in; reported dissatisfaction)	Ineffective sexuality patterns
Stress from caring for chronically ill person	Caregiver role strain
Stress from locating to new environment	Relocation stress syndrome
Substance use as a coping behavior	Ineffective coping
Substance use (denies use is a problem)	Ineffective denial
Suicidal	Risk for suicide; Risk for self directed violence
Suspiciousness	Disturbed thought processes; Ineffective coping
Vomiting, excessive, self induced	Risk for deficient fluid volume
Withdrawn behavior	Social isolation

Case Scenarios

Scenario 1:

Michael is a 7 year old child who has been in foster care for 8 months due to his mother attending inpatient drug treatment. He maintains a close relationship with his mother, and has fit well into the foster family. He has a good relationship with both his foster parents and his foster siblings, but he has few behavioral problems. Although he is somewhat emotionally immature, he does well in school. Over the last several months, the foster parents have reported concerns about Michael. They report he seems "on edge" almost all the time. He has difficulty sleeping, and often insists one of the foster parents lay down with him until he falls asleep and he often wakes during the night frightened and calls for his foster parents. The foster parents report that Michael becomes concerned about his homework being done correctly, almost to the point of obsession. When they have questioned him regarding this concern, he denies that his teacher has ever commented negatively about his performance or homework. The teacher has confirmed this. There have been many occasions where Michael has done the same assignment repeatedly (2-3 times) because he was not satisfied that it was done "good enough". When he is reassured that his teacher is happy with his work, he presents many "what if" scenarios (i.e. what if she doesn't like my handwriting; what if I forget to hand it in; etc.). Recently, Michael has stated that he is concerned about his health. He worries "constantly" that something "could be wrong", but he is unable to explain any reason why. He becomes very upset about this issue, unable to sleep, crying uncontrollably when this is discussed or for no apparent reason, etc. The foster mother has found him watching health programs on television, and Michael becomes very upset when he hears her on the phone talking about anyone who may be

ill. Michael has not been ill recently, and according to his mother has never had a significant health problem. He has had no close experience with serious illness or death. Michael's foster mother took him to the doctor for a full examination, and the doctor reassured him that he is perfectly healthy, but this has not alleviated Michael's fears. When spoken to, Michael is able to acknowledge he has no basis for his fears, but states he "can't help it". He has reported feeling nauseous and having headaches, and will not go to friends' houses to play, although he will invite children over to play with him. The foster parents have stated that these behaviors are beginning to put a strain on the family as a whole and are requesting help in dealing with these issues.

Scenario 2:

Colleen is a child whose family is currently receiving in-home services from your agency. Concerns that warranted the agency's involvement included the conditions of the home and mother's difficulty meeting the basic needs of the children due to lack of resources. The focus of the service plan is assisting mother to improve the living conditions and helping mother improve her parenting to four young children. Colleen is 5 years old and is the youngest of four siblings. For the past two years, she has been home alone with her mother everyday while the rest of her siblings attended school. Colleen started kindergarten this year, and you, the caseworker, have received reports that her attendance to this point has been inconsistent and that the mother seems overwhelmed with the task of getting her to school. The teacher reports that Colleen does well in school, when she attends, and that she has made friends. Colleen seems to be on target developmentally. When this issue is discussed with mother, she reports that

Colleen becomes upset every morning when it is time to go to school. The mother reports this behavior actually begins the night before when it is time for Colleen to go to bed. On school nights, Colleen becomes tearful, questioning her mother repeatedly about what she will be doing when Colleen goes to school and if she will still be there when Colleen returns from school. Colleen often has difficulty falling asleep on school nights and she follows mother around the house almost constantly, refusing to let mother out of her sight. She screams and cries when it is time to go to school, and has even thrown up. Colleen's mother is at the end of her rope with the tantrums and many times has stated that it is just easier to allow her to stay home from school.

Scenario 3:

You are currently investigating a case in which a father punched a 16 year old boy, causing him to have a black eye. In the course of the investigation, the father discussed the fact that the altercation occurred after he received yet another notification that his son, Jay, had been late for school. Jay's father reports that this occurs several times a week, on average, and that this is an increasing source of stress for the family as Jay receives after school detention which has a significant impact on the family's evening schedule due to transportation and other issues. Jay's grades have dropped significantly as a result of his absences. Jay's father also reported that he came home one day to find that Jay had not gone to school at all. When questioned why, Jay explained that a rubber band that he wore around his wrist had broken and he did not feel he could go to school without wearing it, fearing what may happen. Jay stated that he did not know what to do, so he stayed home. Jay's father reports that Jay is very "particular" about his

belongings and routines, and is easily upset, often to the point of extreme anger and aggression, if anything is out of order or his routine is interrupted. One example the father gave was that, when getting dressed, Jay has to put his right pant leg on first, placing his foot directly in his shoe so it does not touch the floor. One day, Jay's father heard a large crash in Jay's room. When he went upstairs to find out what was going on, Jay's right shoe was not on the floor where it was supposed to be, so he was unable to complete his routine. He was so frustrated that he picked his shoe up and threw it, breaking his lamp. He then had to undress completely, and get dressed all over again. Jay's father was able to give several other examples of such "rituals", including shutting the toilet seat, lifting it again, and closing it; turning on and off light switches; touching the same point on the wall when he goes down the stairs; etc. If he is unable to complete these routines or behaviors, he becomes extremely anxious or angry. When the caseworker attempted to speak to Jay about these issues, Jay became very defensive, stating he is "not crazy" and that his dad is just making a big deal of nothing.

Instructions: Read your case scenario and answer the following questions.

1. List the concerning behaviors of the child/adolescent.
2. Write down 3 questions that you, and the professional, should ask to elicit more information about the frequency, intensity and duration of the child/adolescent's behaviors.
3. Identify the next steps in working with this child/adolescent.

Video Materials:

1. Depression video
2. Schizophrenia video
3. OCD video
4. Anxiety video
5. ECT video
6. Addiction video
7. Mental disorders in children video
8. Films depicting people with bipolar disorder, including *Pollack* and *Lust for Life.*
9. Films that include people with personality disorders and discuss characteristics: *One Flew Over the Cuckoo's Nest* (antisocial), *Fatal Attraction* (borderline), *Wall Street* (narcissistic).
10. The video series *Thinking Allowed.*