Learning Centre

Queensland Centre for **Mental Health Learning**

11362NAT - Observing and Documenting the Mental State Examination

West Moreton Health | Queensland Government

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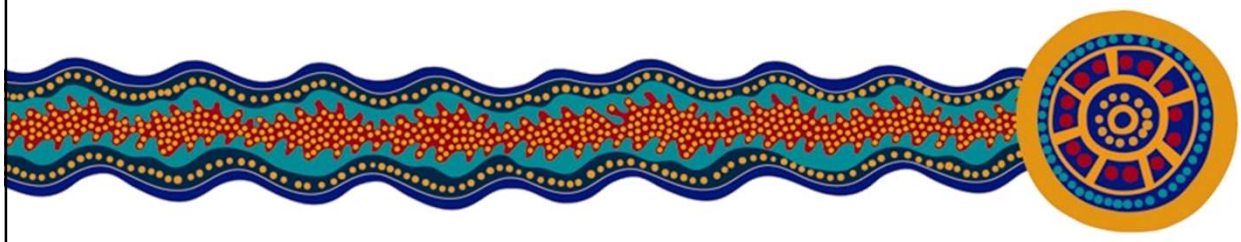

Queensland Health and the Learning Centre acknowledge the Traditional Owners and Custodians of the land, waters and seas, and pay our respects to Elders past, present and future.

We recognise the **historical and ongoing impacts of colonisation** including the dismantling of culture and heritage, extinguishment of language, dislocation from Country and deliberate separation of families and communities. We acknowledge the social, emotional, and physical consequences for Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander communities continue to demonstrate resilience and strength, and generously share their culture and traditions.

Aboriginal and Torres Strait Islander peoples are advised that this publication may contain the names and/or images of deceased people.

'Making Tracks' artwork produced for Queensland Health by Gilimbaa.

Queensland Health 2010: *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033* – Policy and accountability Framework Brisbane 2010; Qld Government, Making Tracks Artwork and Protocols.

2

2

We recognise the lived-living experience of those with a mental health condition, those impacted by suicide or substance use, and the contribution families, friends, carers and staff make to their recovery.

West Moreton Health is committed to ensuring every child and young person is seen, heard, and feels safe by creating inclusive environments where their voices are valued, their needs are understood, and their safety is everyone's responsibility.

3

Housekeeping


Toilets and facilities


Fire exits and evacuation


Mobile phones to silent


Breaks: 10-15 minutes


Group agreement (confidentiality, respect and participation)


CPD hours/statement of attainment


Attendance record


Online assessment

4

Online etiquette and housekeeping


Mute when not speaking


Facilitator screen sharing


Use of the chat room


Attendance record


Mobile phones to silent


Technical troubleshooting


CPD hours/statement of attainment


Group agreement (confidentiality, respect and participation)


No access while driving

5

When you have successfully completed the workshop and the assessment component of this course, you will be able to:

- observe clinically relevant features for each of the core components of the mental state examination (MSE)
- consider the influence of contextual factors on the person's presentation
- record clinically relevant observations and provide a rationale for clinical judgements made
- apply the minimum standard for mental state examination documentation when making records.

6

Program

Observing and documenting the Mental State Examination

First half
Environmental, developmental, personal, and cultural factors
The minimum standard for MSE reporting
Appearance and Behaviour
Mid break (15 minutes)
Speech
Mood and Affect
Perception
Session end/Break (30 mins)

Second half
Thought content
Thought form/flow
Mid break (15 minutes)
Insight
Judgement
Cognition
Overview of the online assessment
Session finish

7

Quick refresher

What are the core components of the MSE?

8

Unpacking the MSE

What is the purpose of the MSE?

How should it be written to give a clear picture of a person's mental state?

9

9

What are the minimum standards for MSE documentation?

- Use objective, unbiased, non-judgemental, non-stigmatising and culturally appropriate language.
- Record the client's own words and phrases.
- Explain your clinical judgements based on evidence and cite examples.
- Make clinically relevant entries for each component; when no observations are possible, explain why.
- **If** you use psychiatric terminology *(you don't have to!),* provide an example/describe what you observe.

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Do Don't

Activity 1: How do we document objectively?

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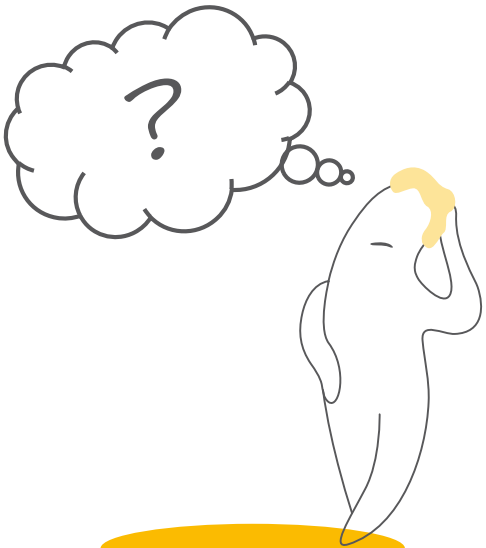
Activity 2:

Consider the context

- Environmental
- Developmental
- Personal
- Cultural.



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Organic factors may also explain a person's behaviour or mental state.

We found 10 common organic factors. They all start with 'P' to help you remember them.

Pee	Parched
Poop	Paralytic
Pain	Polydipsia
Pus	Periods
Pills	Punched

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At a minimum, always record what is clinically relevant.

What helps us decide what is clinically relevant?

1. Is the experience or situation impacting the person's or others' wellbeing (positively or negatively)?
2. Is it impacting the person's functioning (relationships, work, study, daily activities), positively or negatively?
3. Is it causing the person distress?
4. Is it creating a risk to self or others?

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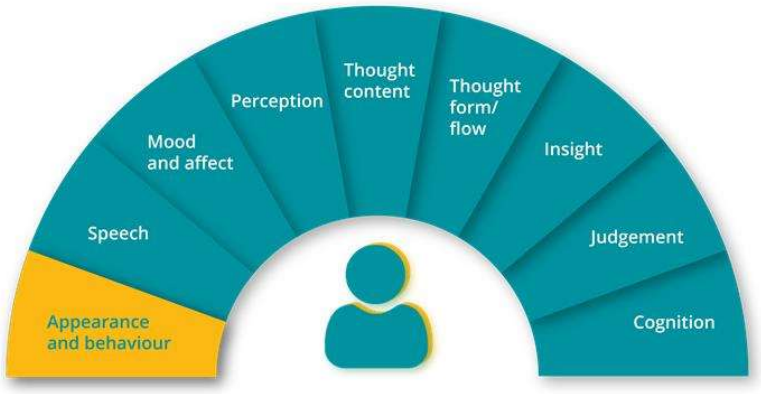

1. Appearance and behaviour

What can we expect to see?

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Appearance

What features are clinically relevant?

- Changes in weight
- Clothing style/grooming
- Hygiene (cleanliness/body odour)
- Unique physical features (injuries, scars, piercings, tattoos, etc.)
- Assistive devices (hearing aids, glasses, prosthetics, etc.)

Consider context

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Behavioural features

- Eye contact/facial expression
- Gestures
- Posture (rigid, stooped)
- Gait
- Limited or restricted movement
- Repetitive or involuntary movements
- Engagement with the interview process.

Consider context

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How would you describe Kevin's **appearance and behaviour**

Video source: University of California, Los Angeles (UCLA).

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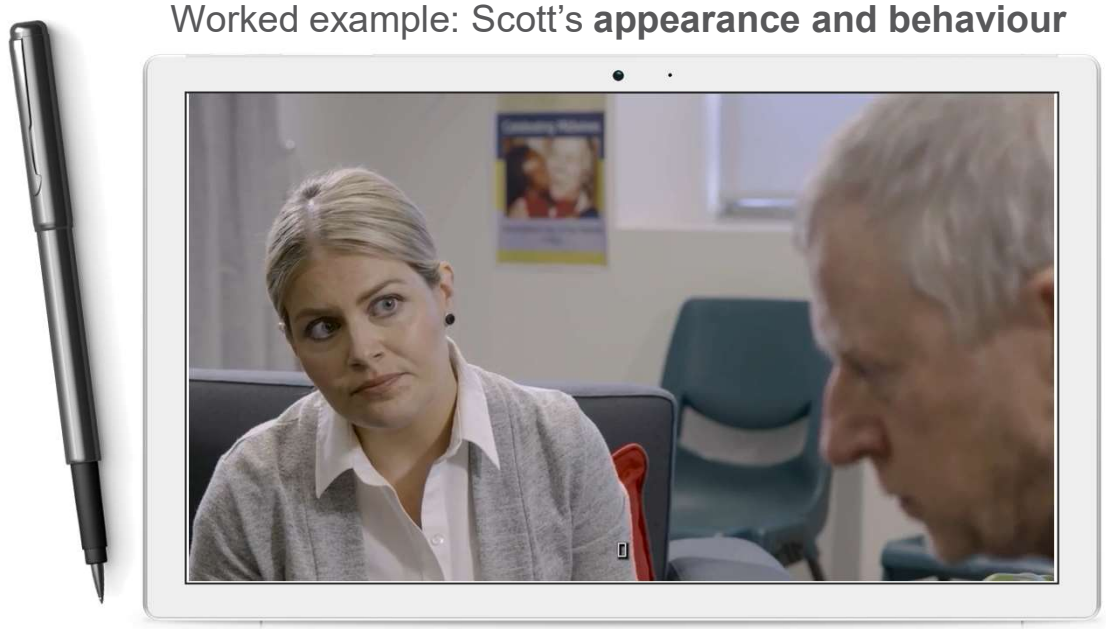
Worked example: Scott's **appearance and behaviour**



Video source: Used with permission from University of Technology Faculty of Health, Sydney.

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Example response for Scott

Appearance and behaviour

Appearance

Behaviour

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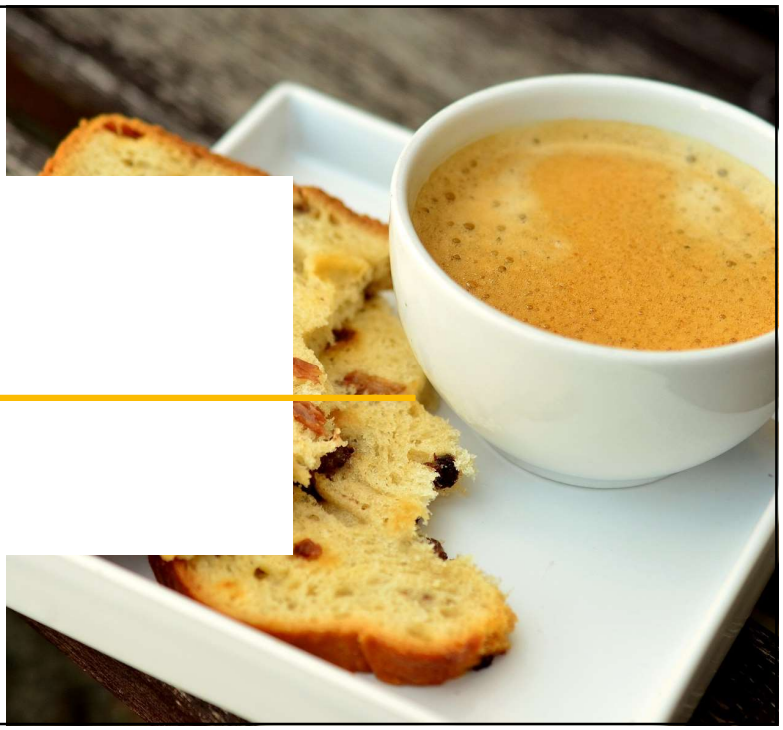
Break

15 minutes



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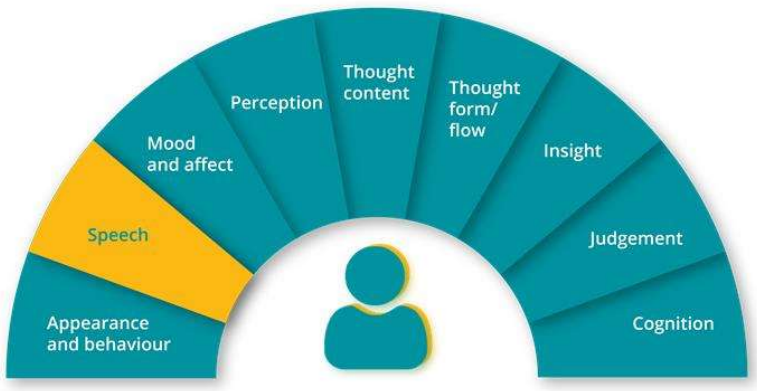

2. Speech

Speech is not what a person says, it's how they say it.

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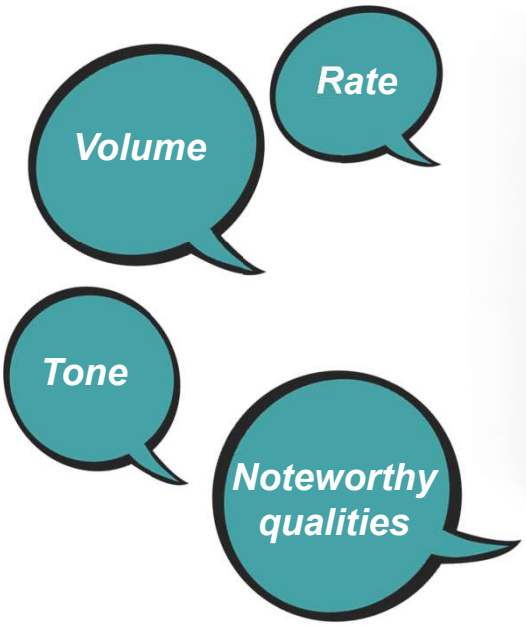

There are 4 features of speech

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Activity 3: Document the features of speech

1

2

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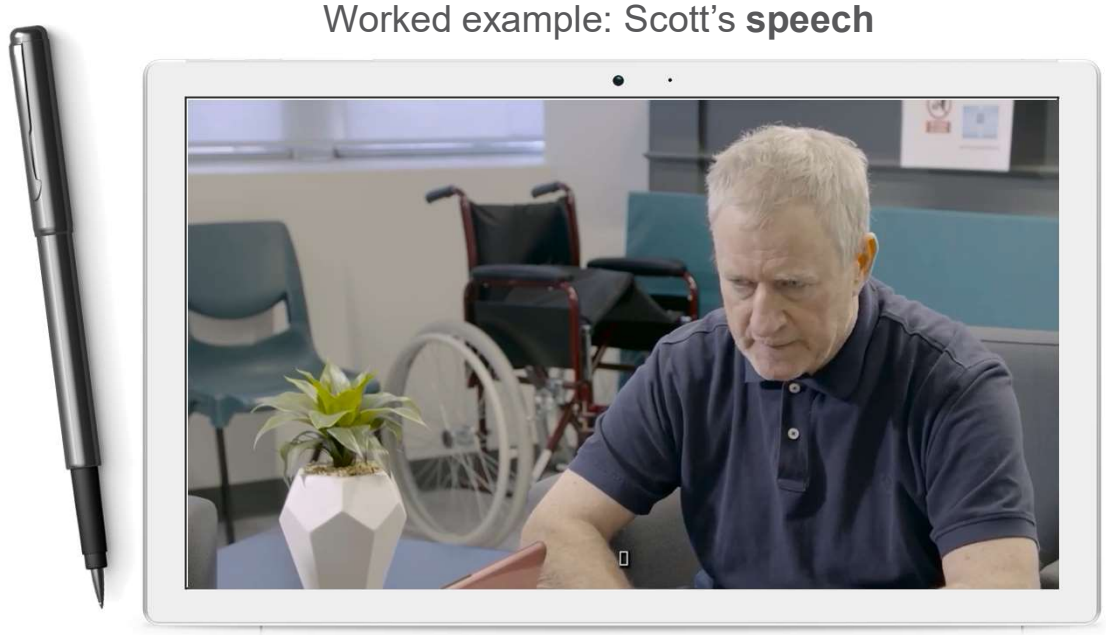
Worked example: Scott's **speech**



Video source: Used with permission from University of Technology Faculty of Health, Sydney.

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Example response for Scott

Speech

Rate:

Volume:

Tone:

Noteworthy qualities:

Consider context

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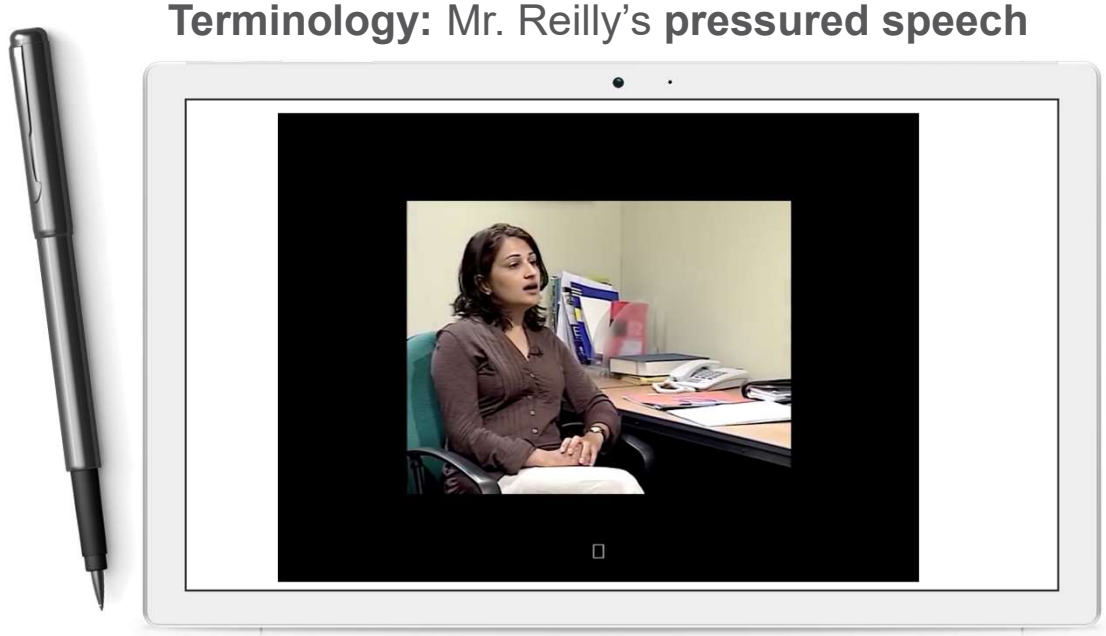
Terminology: Mr. Reilly's **pressured speech**



Video source: University of Nottingham.

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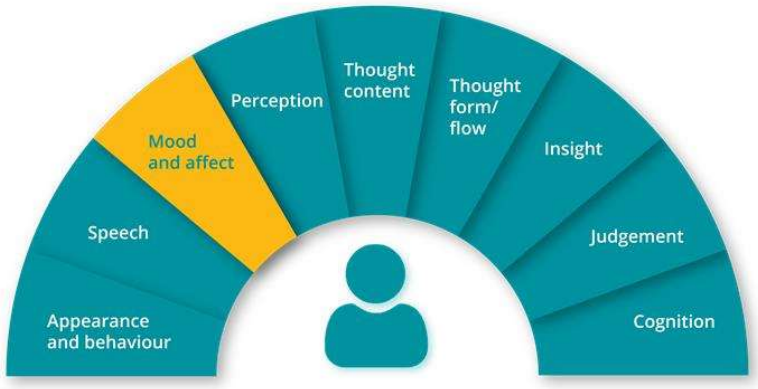

3. Mood and affect

Why do we focus on a person's feeling state?

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How to differentiate **mood from affect**

Mood

Internal emotional state - reported by self.

Tends to be more sustained.

Affect

Externally expressed emotions - seen by others.

Tends to be more fleeting/changeable.

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Activity 4(a): The four features of **Mood**

Document mood by recording.

1. Emotion type:	How the person describes their mood.
2. Depth:	The person's perception of the depth of their mood (e.g. 'sad' vs 'devastated'; may include a scale measure such as 2 out of 10).
3. Duration:	How long the person has been experiencing their mood (e.g. 2 weeks, 2 months).
4. Fluctuation:	How changeable their mood has been over a period of time (e.g. minor change, rapid change, etc).

Peter reported feeling 'extremely sad' over the past 2 months. He described that 'this is the hardest time of [his] life', and that he has not felt any joy during the same period.

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QUIZ: Which feature of **mood** is being assessed by each question?

Choose from: Emotion type/Depth/Duration/Fluctuation

1. How long have you been feeling sad?
2. How would you describe your mood lately? What have you been feeling?
3. Other than extreme sadness, have you felt differently when you're doing different activities?
4. On a scale of 0-10, with 10 being the most intense, how would you rate your sadness?

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Activity 4(b): The features of **affect**

1. Range:	Does the person show a variety of emotional expression **(full range)**? Or is it **restricted** to a particular emotion?
2. Intensity:	How **strongly** is their emotion being expressed? (e.g. sniffing softly vs sobbing).
3. Reactivity:	Emotional expression changes/doesn't change with the topic or situation.
4. Congruence:	Does their emotional expression **match** their reported mood?

Peter's affect was restricted to sadness, shown as downcast eyes and monotone speech.
Emotional expression did not change despite a change in topic. Mood and affect congruent.

Consider context

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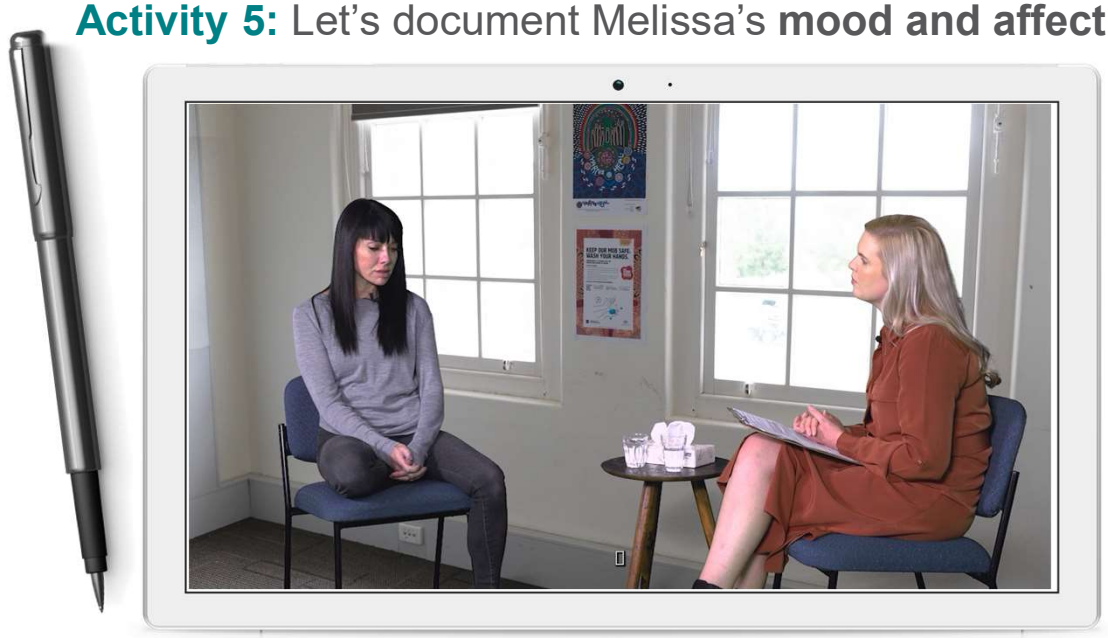
Activity 5: Let's document Melissa's **mood and affect**



Video source: Learning Centre developed.

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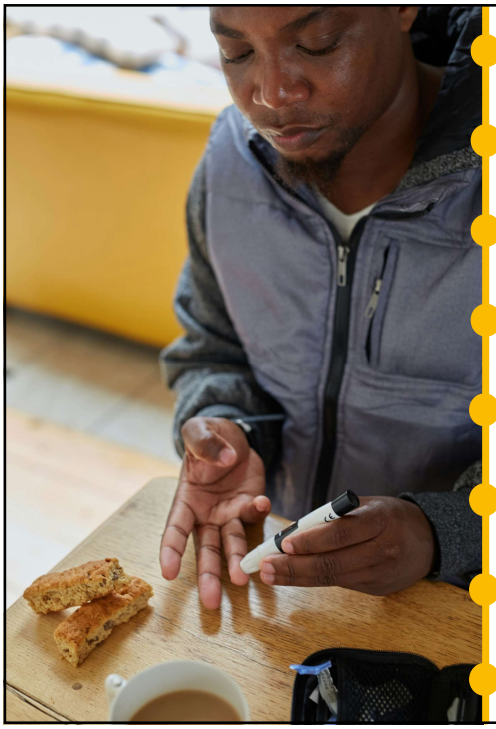

Neurovegetative symptoms

What are they and why are they important?

- Sleep
- Appetite
- Weight gain/loss
- Interest
- Motivation
- Energy
- Libido.

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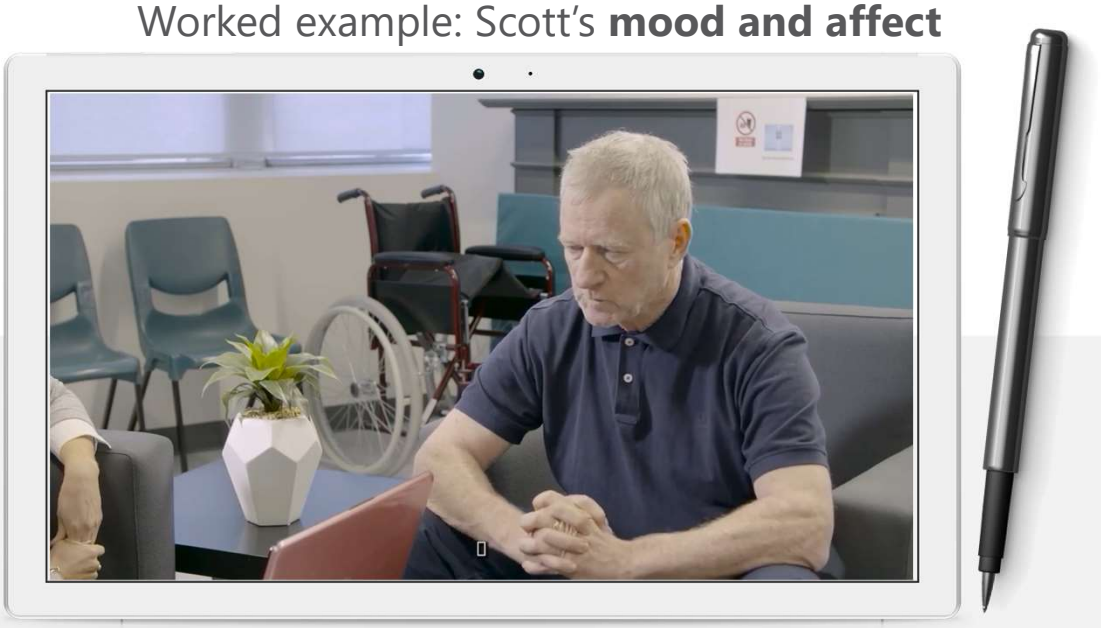
Worked example: Scott's **mood and affect**



Video source: Used with permission from University of Technology Faculty of Health, Sydney.

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Example response for Scott

Mood and affect

MOOD

Emotion type:

Depth:

Duration:

Fluctuation:

AFFECT

Range:

Intensity:

Reactivity:

Congruence:

Neurovegetative:

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Common terminology used for affect

Labile
Frequent intense emotional reactivity; easily changeable without a clear trigger and, out of proportion to events/circumstances.

Blunted
Reduced emotional reactivity and expressiveness, especially when talking about topics that would normally evoke emotions.

Flat
There is no, or nearly no, emotional expression.

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Exercise: How would you document **affect** for Simone?

Video source: Learning Centre developed.

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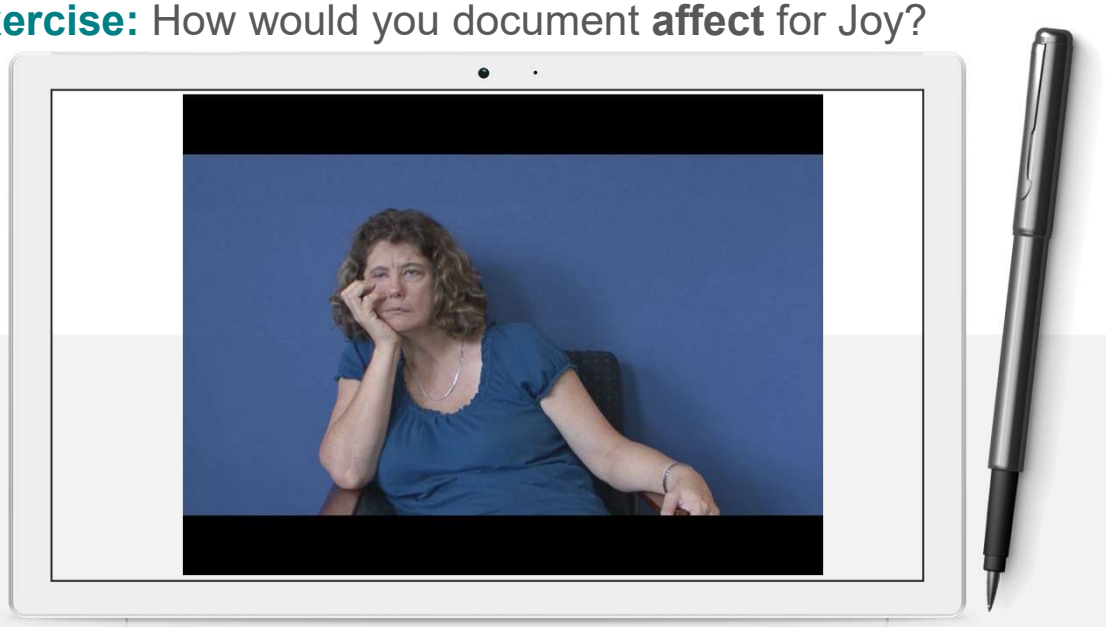
Exercise: How would you document **affect** for Joy?



Video source: Learning Centre developed.

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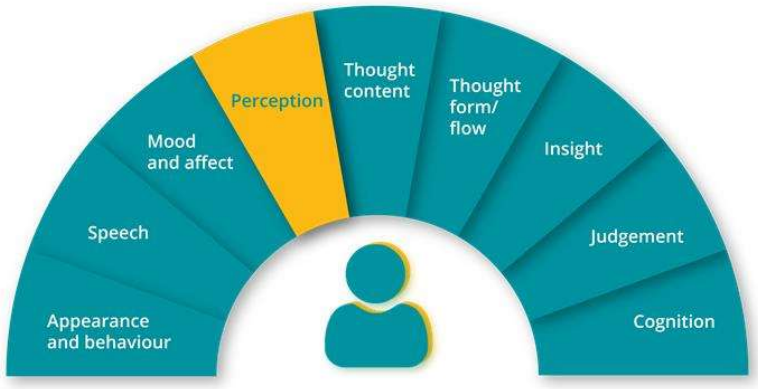

4. Perception

What relevant sensory disturbances is the person having?

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Sources of sensory experience

Sensory sensitivities: Extreme discomfort during everyday sensory experiences.

Illusions: Misperceptions or misinterpretations of real life stimulus.

Hallucinations: False sensory experiences in the absence of real life stimulus.

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What types of hallucinations might someone experience across the five senses?

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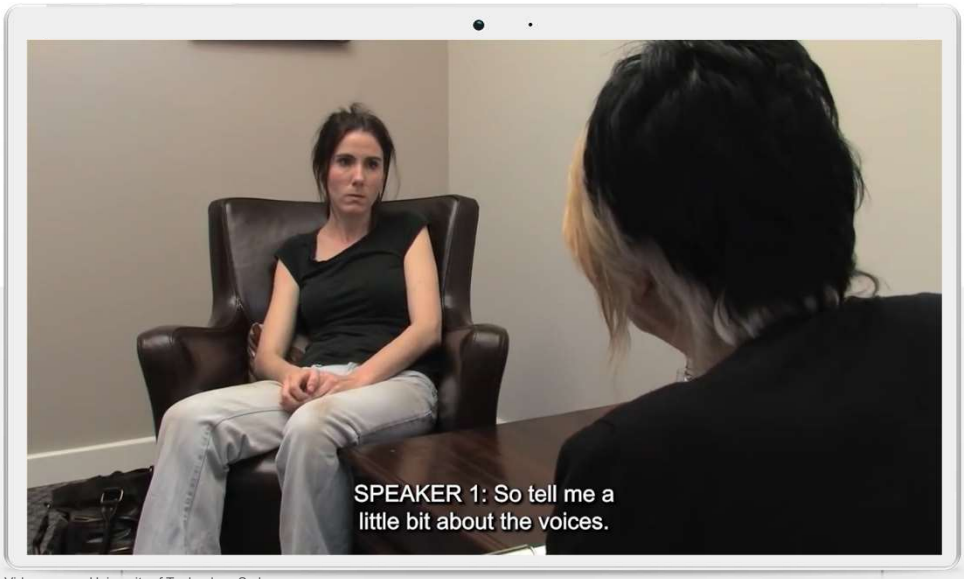
Document: Lisa's **auditory hallucinations**



Video source: University of Technology Sydney

Consider context

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When **perception** has a **cultural context**

Video source: Learning Centre developed.

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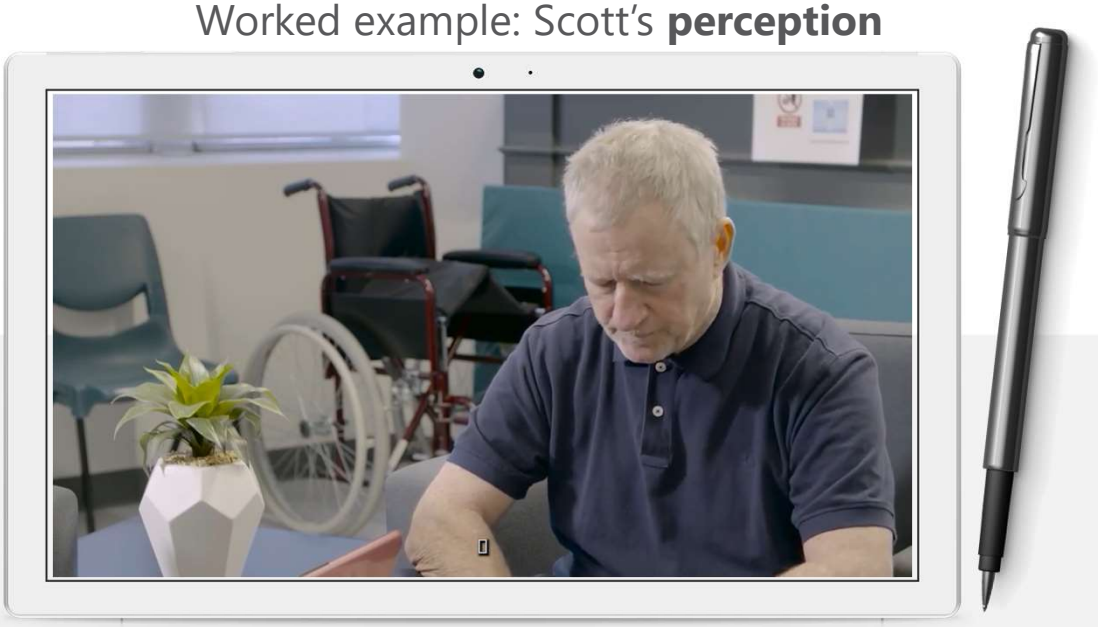
Worked example: Scott's **perception**



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Example response for Scott

Perception

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Lunch

30 minutes

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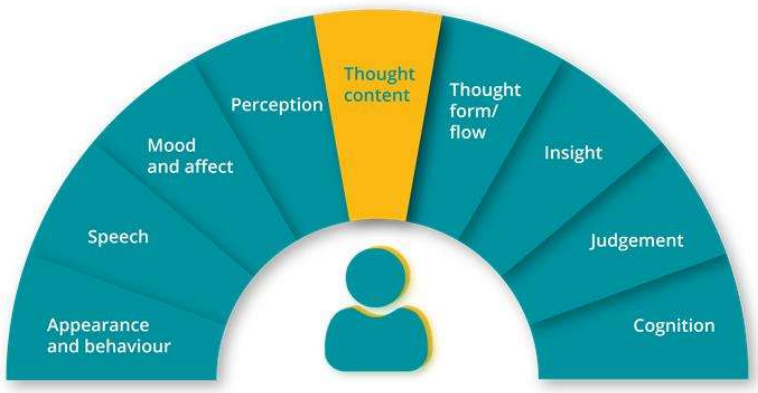

5. Thought content

What part of the discussion do we document?

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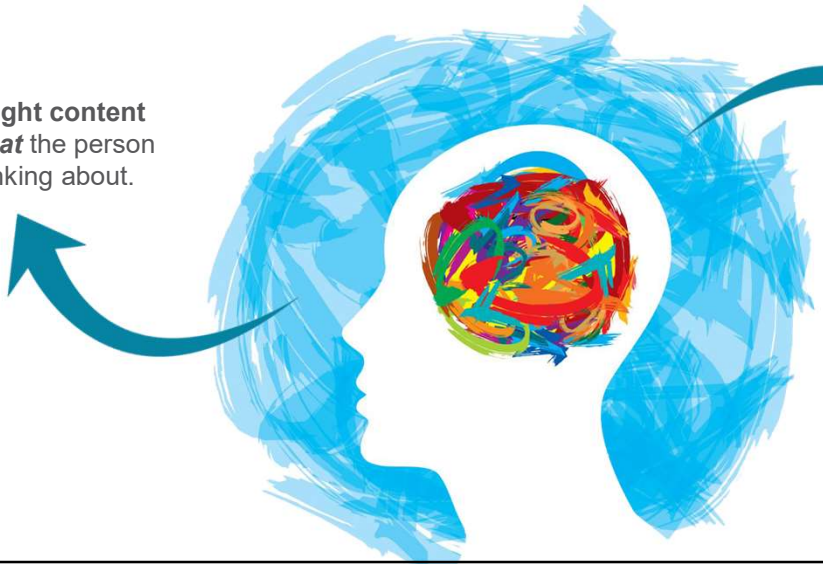
Thought content vs Thought form/flow

How do we differentiate them?

Thought content
is ***what*** the person
is thinking about.



Thought form/flow
is ***how*** thoughts are
connected to each
other.

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The features to document from **thought content**

- The ***main topics*** occupying the person's thoughts (not just disturbed thoughts).
- Thoughts that are causing the person ***distress.***
- Thoughts impacting the person's day-to-day ***functioning*** (positively or negatively).
- Thoughts that signal a ***clinical risk***.

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Indicators of risk

Thought content relating to harm to **self** or **others**

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Andy's **thought content** (including risks)

Video source: University of Nottingham

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Activity 6: Types of thought disturbances

- Phobias
- Delusions
- Obsessions
- Compulsions
- Preoccupation of thought.

Consider context

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Worked example: Scott's **thought content**

Video source: Used with permission from University of Technology Faculty of Health, Sydney.

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Example response for Scott

Thought content

Main topics:

Risks indicated:

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Example response for Scott

Context

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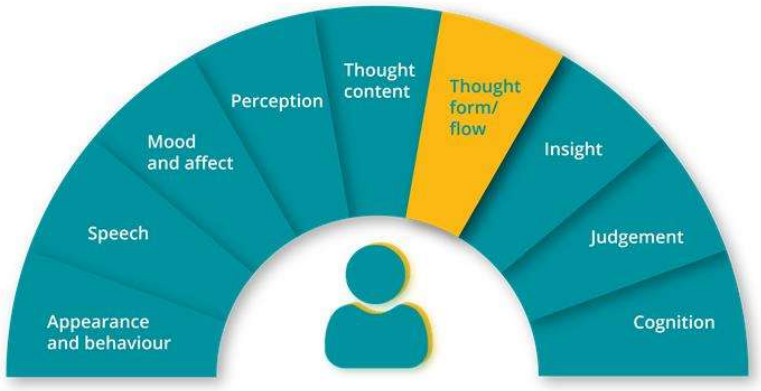

6. Thought form/flow

Who remembers the difference between thought form/flow and thought content?

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The features for **thought form/flow**

What is the **amount** and **rate** of thoughts?

How **connected** are the thoughts **to each other**?

How **connected** are the thoughts **to the question** or **central idea**?

Consider context

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How do I document **thought form and flow?**

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Example response for Scott

Thought form/flow

Amount and rate:

Connected to each other:

Connected to central idea:

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Activity 7: Thought form/flow terminology

Circumstantiality	→	Talking at length around a point with excessive detail; characterised by over-inclusion of detail.
Tangentiality	→	Replying in an irrelevant or digressive way, whereby the question is not addressed.
Flight of ideas	→	Nearly continuous flow of accelerated thoughts or speech with abrupt changes in topic at the paragraph level.
Loosening of associations	→	There is very little discernible connection between ideas, with shifts from one subject to another at the sentence level.

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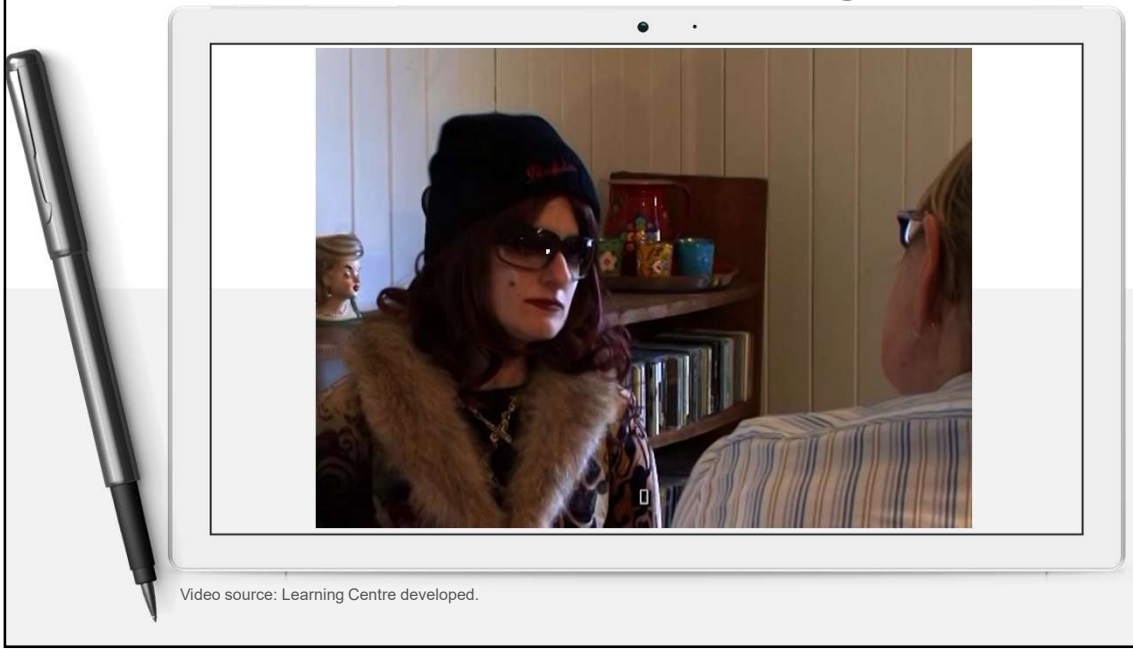
Deborah demonstrates: **Flight of ideas**



Video source: Learning Centre developed.

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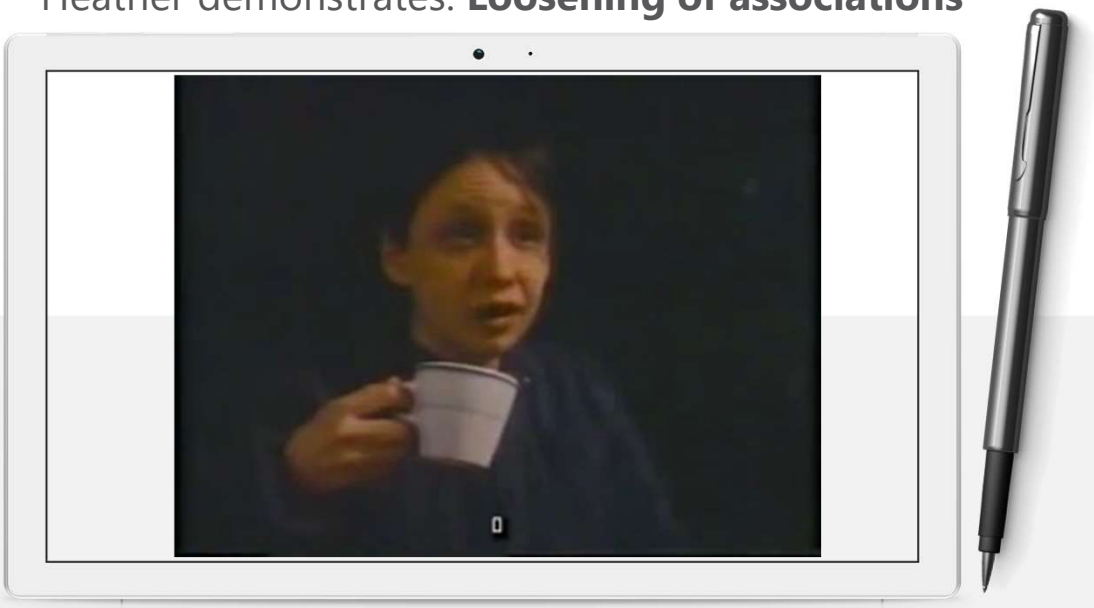
Heather demonstrates: **Loosening of associations**



Video source: National Institute of Mental Health, St Elizabeth's Hospital, Washington DC.

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Break

15 minutes

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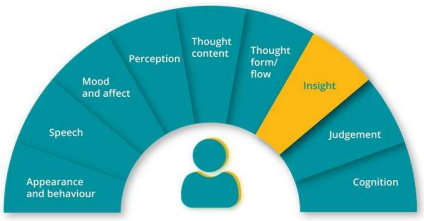
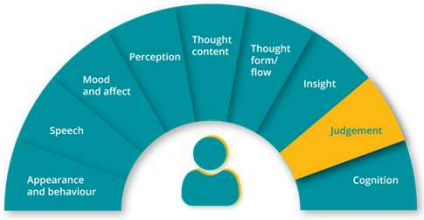
7. Insight and
8. Judgement



In small groups, share a situation where you had?

- Good insight and poor judgement.
- Good judgement and poor insight.



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Insight and judgement

Insight refers to the person's **awareness** of their symptoms/situations, the impacts on their functioning and the causes of their experiences.

Judgement is how people **make decisions,** their **reasoning** and **considerations.**

It is possible to have one without the other.

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Activity 8: Insight

1. Is the person **aware** of their symptoms/situations?
2. Does the person understand how their symptoms/situations **impact functioning**?
3. How do they **explain the reason** for their symptoms/situations?

Are beliefs, values, or personal factors playing a part?

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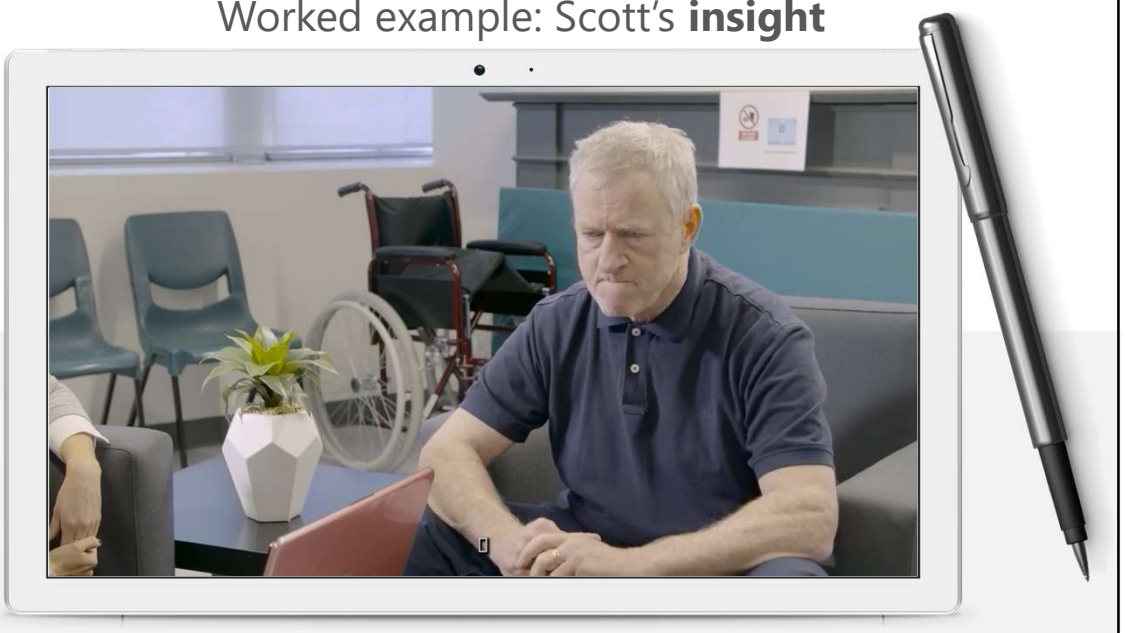
Worked example: Scott's **insight**



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Example response for Scott

Insight

Awareness of symptoms:

Impact on functioning:

Explanation for symptoms:

Consider context

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How can **context** influence **insight**?

Video source: Learning Centre developed.

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Activity 9:
How to assess **judgement**

1. What **behaviours** are helpful/harmful?
2. **How** is the decision being made?
   - Reality or non-reality based.
3. What **impacts/likely outcomes** have been considered?

Consider context

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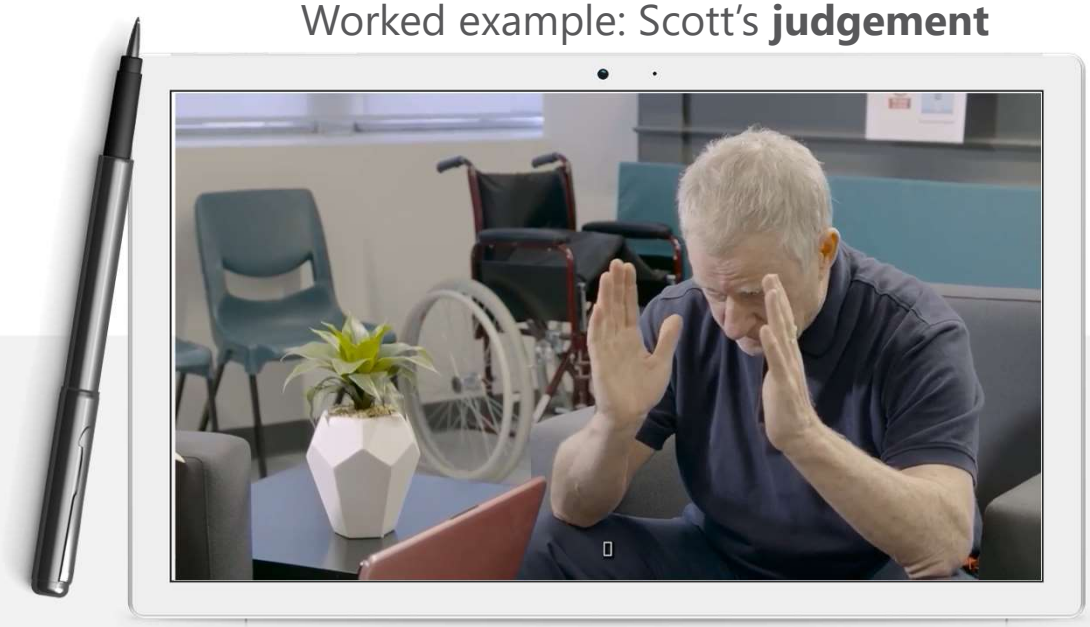
Worked example: Scott's **judgement**



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Example response for Scott

Judgement

Behaviour:

Decision:

Impacts/likely outcomes considered:

Behaviour:

Decision:

Impacts/likely outcomes considered:

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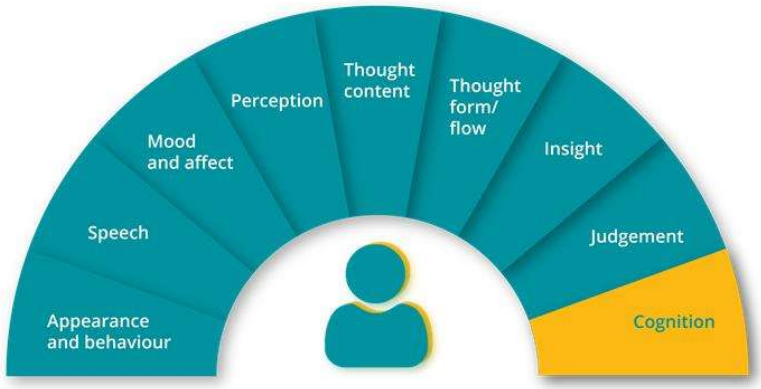

9. Cognition

Cognition is assessed throughout the entire assessment.

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Quiz: What do we assess in **cognition**?

1. Alertness	Aware/responsive or drowsy/unresponsive.
2. Orientation	Aware of who you are, where they are and the day/time.
3. Memory	Able to remember daily routines, appointments and historical information.
4. Concentration	Able to focus, answer questions, and remain engaged during the interview.

Consider context

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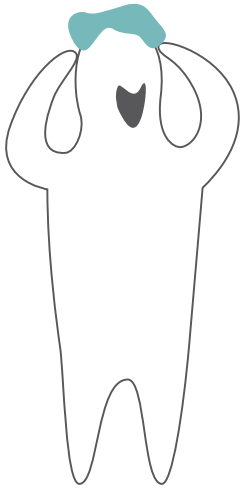

When **cognition** is affected

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Example response for Scott

Cognition

Alertness:

Orientation:

Memory:

Concentration:

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There is no need to write ‘not formally assessed’

All features of cognition can be observed without having to administer a standardised test.

What if you’re unable to observe or assess all the MSE components?

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Online Assessment Process

1 Log onto our LMS

3 Assessment task 2
Watch video + short answer questions

Assessment task 1
Multiple choice questions 2

Assessment task 3
Watch video + complete MSE 4

Submit assessment within 4 weeks

We will contact you with results or a request for further information within 4 weeks from submission

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Online evaluation

Queensland Centre for Mental Health Learning

To improve the quality of our courses, the Learning Centre uses online evaluations.

Please ensure that your attendance has been **recorded by your trainer** to complete the course, access your certificate, and receive evaluation emails.

The evaluation process

Step 1
Workshop booking
Sign up - your booking triggers a series of processes.

Step 2
Pre evaluation
After signing up, an email confirms your booking. This email contains important details and the pre evaluation link.

Step 3
Post evaluation
Upon workshop completion, you will receive access to your certificate and post evaluations.

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Queensland Centre for Mental Health Learning

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