# Unit 2.2

# Mental State Examination, Formulation and Treatment Planning

# Unit 2.2: Mental State Examination, Formulation and Treatment Planning

## Unit Descriptor

Unit 2.2 has been developed to support Qld Mental Health staff to acquire, refresh and maintain core skills and knowledge related to completing Mental State Examinations (MSE), formulations and treatment planning. This Unit addresses the essential aspects covered within the MSE, appropriate terminology to describe symptomatology within an MSE, and how to write an MSE based on your assessment and the presentation of a child or adolescent. The Unit educates clinicians on the components of a comprehensive and systematic formulation and describes how this framework can be utilised to guide treatment planning. The training utilises a variety of learning strategies, including a DVD presentation, practical and reflective exercises.

## Learning Objectives

Mental State Examination

1. Demonstrate a sound theoretical knowledge and understanding of the components of a Mental State Examination including appearance, behaviour, speech, affect and mood, attitude, thought processes, thought content, perception cognitive functioning, fantasy, concept of self, insight and judgement

2. Demonstrate an ability to complete a Mental State Examination utilising the appropriate terminology to describe presentation and symptomatology of a child or adolescent

3. Capture essential information and psychopathology in a Mental State Examination

Formulation

4. Demonstrate the ability to write a formulation as a concise summary of the presenting problem, predisposing factors, precipitating factors, pattern/coping style, perpetuating factors, potentials and prognosis.

5. Formulation demonstrates an understanding of the clients presentation through a comprehensive and logical explanation of the case

6. Formulation encompasses the key assessment information and collateral data

7. Formulation is utilised to inform diagnosis and assist in the development of a treatment plan

Treatment Planning

8. Treatment plan is guided by the assessment information, diagnosis and formulation

9. Treatment plan is developed in collaboration with client and identifies the problem, goals, intervention strategy, person responsible and time frames.

# Unit 2.2

# Introduction to Mental State Examination, Formulation and Treatment Planning

DVD's and Associated Learning Materials

# DVD 2: The Assessment and Management of Mental Health Problems in Children and Adolescence

## Presenter: Dr James Scott

## DVD Overview

This DVD highlights the objectives of a clinical interview and provides detailed information about the components of an initial assessment. More specifically, it illustrates how to conduct a contextual assessment, discusses the elements of a Mental State Examination, introduces the use of the Bio-Psycho-Social Model and the 7 P's as a framework for gathering and organising assessment information into a comprehensive formulation, and provides guidance in completing goal directed treatment plans. The DVD includes a role-play that demonstrates how to conduct an initial assessment with an adolescent and parent.

The DVD contains 2 parts:

- An overview and introduction to Initial Assessments, Mental State Examinations, Formulations and Treatment Planning
- A brief role-play demonstrating how to conduct an Assessment with an adolescent and parent

Presenters:

- Dr James Scott
- Adult actor used in fictional case study – Judith Piccone
- Child Actor used in fictional case study - Jarryd

Case Study Notes:
This case study was based solely on fictional characters. Similarities to persons or real events are purely co-incidental**.**

**<u>Please Note:</u> This is the same DVD that you will have viewed for Unit 2.1: Child and Youth Mental Health Assessment. Please refer to pages 4 – 15 of Unit 2.1 for accompanying resources, PowerPoint handouts, Case Study details, Exercises related to the role-play and Suggested Responses.**

# Mental State Examination

### Introduction

A Mental State Examination (MSE) is a systematic approach to assessing and evaluating an individual's mental state at a specific point in time, and involves the consideration of the individual's physical, cognitive and emotional characteristics. The aim of the MSE is to clarify the nature of the individual's mental health problems, assess current mental state, identify early warning signs for relapse, and to provide a baseline of functioning to use as a comparison.

An MSE is usually completed during the initial interview. Subsequently, clinician's informally assess and observe a client's Mental State on an ongoing basis. A formal MSE may also be necessitated by a change in clinical presentation, prior to revoking an ITO (Involuntary Treatment Order) or Forensic Order, and prior to discharge and at follow-up post discharge. (Ref: Inpatient Unit Training Package, 2001)

### MSE Forms

Space for an MSE is included on the Queensland Health approved form found in the section of this package under 'Forms' and is entitled:

- Consumer Assessment

A brief mental state also needs to be included on the intake assessment for entitled:

- Consumer Intake

### DVD reference for MSE

1. Description of what to include in a mental state assessment - DVD 2

### Helpful Tools in conducting and recording a MSE

1. The User Guide to CYMHS Clinical Documentation suite has useful information on what to include in a MSE. The Consumer Assessment form itself describes the items to address in recording an MSE.
2. Following is a summary of items to include in an MSE and suggested questions to use when interviewing a child or young person in order to obtain information for a comprehensive MSE and assessment
3. Appendix 1 contains a useful article from Child and Adolescent Psychiatry – A comprehensive textbook. (Ed's Melvin Lewis), Lippincott, Williams and Wilkens (2002) on conducting a thorough MSE, looking at all aspects including developmental areas.

# Mental State Examination Handout

***Ref:*** *RCH&HSD CYMHS Training Handouts (Mar 2008) – by Judith Piccone, Dr James Scott & Naomi Kikkawa*

- MSE is only one component of psychiatric evaluation - evaluates current state
- MSE referred to as the psychiatric equivalent of a physical examination
- MSE considered to be an objective evaluation - is gathered during the context of the psychiatric (initial) interview (considered subjective)
- MSE considered important as part of the assessment required for developing formulation, diagnosis and treatment plan
- Originally developed with adults - need to take in developmental considerations
- Can expand some information with follow up tests, i.e cognitive assessments, speech and language assessments

## MSE Components

**General Appearance**
- Physical characteristics
- Apparent age
- Dress/clothing
- Grooming
- Physical abnormalities

**Behaviour and Motor Activity**
- Eye contact
- Posture
- Facial expression
- Body movements
- Level of consciousness
- Impulse control
- Separation

**Attitude**
- Co-operativeness towards interviewer
- Degree of rapport
- General manner

**Speech**
- Tone of voice
- Quality of speech
- Fluency
- Rate of speech
- Impairments
- Comprehension

**Mood**
- Euthymic
- Dysphoric
- Euphoric
- Angry
- Apprehensive
- Apathetic

**Affect**
- Appropriateness
- Intensity
- Range
- Reactivity
- Mobility

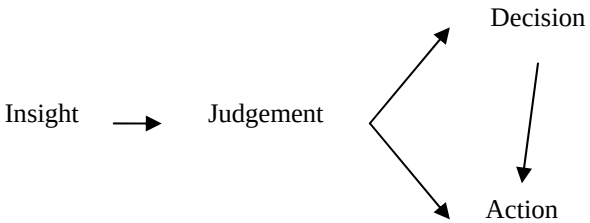
**Perception**
- Hallucinations
- Distortions
- Depersonalization
- Derealization

**Thoughts - Content & Process**
- Content - delusions, obsessions, beliefs, phobias, ideas of reference, suicidality
- Process - flight of thoughts, circumstantiality, blocking, tangentiality, suicidality

**Cognition**

- Orientation to time, place, person
- Attention & Concentration
- Memory
- Language
- Reading, Drawing, Writing
- Abstraction

**Insight & Judgement**




## MENTAL STATE EXAMINATION: CHILD (Primary School)

**1. Appearance** *(physical maturation, nutrition, body type and physique, skin, hair, facial features, distinguishing features, grooming, dress)*

**2. Motor Behaviour** *(activity level, posture, gait, balance, coordination, power, tone, abnormal movements, startle response, mannerisms, habits, rituals, stereotyped movements)*

**3. Voice, Speech and Language** *(amplitude, pitch, tone, tempo, prosody, phonation, rhythm, fluency, articulation, comprehension, vocabulary, syntax, conversational ability, use of gesture, accent)*

**4. Relationship with Examiner** *(eye contact, cooperativeness, dependency, friendliness, withdrawal, evasiveness, fear, anxiety, hostility, suspiciousness, indifference, invasiveness, dramatism, suggestibility)*

**5. Affect and Mood** *(range, control, congruity, elevation, depression, suspicion, anxiety, fear, anger, issues related to particular affects)*

**6. Thought Processes** *(tempo, fluency, goal-direction, coherence, interruptions)*

**7. Thought Content** *(obsession, compulsion, hallucination, delusion, illusion, depersonalisation, de-realisation, deja vu, phobia, flashback (intrusive traumatic imagery), abnormality of general or special sensation, abnormality of body image,distortion of the sense of time, confabulation, fabrication; preoccupation with identity,physical health, mental health, personal competence, or the past or future)*

- ***Risk Assessment***
  - ✓ **suicidal ideation**
  - ✓ **impulses to harm self**
  - ✓ **impulses to harm others**
  - ✓ **impulses to take risks**
  - ✓

**8. Brief Screen for Cognitive Functioning**

- ***Orientation***
- ***Concentration***
- ***Memory***
  - ✓ **Immediate**
  - ✓ **Recent**
  - ✓ **Remote**
  - ✓ ***Estimated Intelligence***

**9. Fantasy** *(dreams, wishes, drawings, free play: productivity, themes, capacity to distinguish fantasy from reality)*

**10. Concept of Self** *(dreams, wishes, drawings, free play: coherence, concepts of personal intelligence, strength, attractiveness, relationship with others)*

**11. Insight and Desire for Help** *(awareness of having a problem, awareness of nature of problem, desire for help)*

**MENTAL STATUS EXAMINATION: ADOLESCENT (High School)**

**1. Appearance** *(physical maturation, nutrition, body type and physique, skin, hair, facial features, distinguishing features, grooming, dress)*

**2. Motor Behaviour** *(activity level, posture, gait, balance, coordination, power, tone, abnormal movements, startle response, mannerisms, habits, rituals, stereotyped movements)*

**3. Voice, Speech and Language** *(amplitude, pitch, tone, tempo, prosody, phonation, rhythm, fluency, articulation, comprehension, vocabulary, syntax, conversational ability, use of gesture, accent)*

**4. Relationship with Examiner** *(eye contact, cooperativeness, dependency, friendliness, withdrawal, evasiveness, fear, anxiety, hostility, suspiciousness, indifference, invasiveness, dramatism, suggestibility)*

**5. Affect and Mood** *(range of affect, control of affect, congruity of affect, issues that trigger particular affects, predominant mood: anger, anxiety, apathy, depression, suspicion, flatness, euphoria, elation, guilt, resignation)*

**6. Thought Processes** *(slowing, acceleration, interruptions, blocking, circumlocution, circumstantiality, perseveration, concreteness, flight of ideas, goal-direction, coherence, looseness of associations, tangential thinking)*

**7. Thought Content** *(obsession, compulsion, hallucination, delusion, illusion, depersonalisation, de-realisation, de ĵa vu, phobia, flashback (intrusive traumatic imagery), abnormality of general or special sensation, abnormality of body image,distortion of the sense of time, confabulation, fabrication; preoccupation with identity,physical health, mental health, personal competence, or the past or future)*

*Risk Assessment*

- ✓ suicidal ideation
- ✓ impulses to harm self
- ✓ impulses to harm others
- ✓ impulses to take risks

Brief Screen for Cognitive Functioning

- *Orientation*
- *Concentration*
- *Memory – Immediate, Recent, Remote*
- *Estimated Intelligence*
- *General knowledge*
- *Social judgement*
- *Abstracting ability*
- *Estimated intelligence*

**9. Fantasy** *(dreams, wishes, drawings: productivity, predominant themes, capacity to distinguish fantasy from reality)*

**10. Insight** *(awareness of being unwell, awareness of nature of problem, desire for help)*

**11. Physiological Functions** *(energy, concentration, memory, interest in people and activities, appetite, weight, sleep, libido, sexual functioning, menstrual history, last menstrual period)*

## Written MSE – Examples

***Ref:*** *RCH&HSD CYMHS Training Handouts (Mar 2008) – by Judith Piccone, Dr James Scott & Naomi Kikkawa*

**Appearance, Attitude, Activity**

Tall, muscular young man who appears stated age. Neatly dressed in blue jeans and shirt. At first reluctant to talk, but then cooperative. At one point arose abruptly from his chair and waved his hands in the air, looking frustrated. Threw a pen across the room.

**Mood and Affect**

She is cheerful and describes her mood as “great”. She is very expressive of her cheerful mood, but affect is mildly labile, with several angry comments and irritability when interrupted by the examiner. Affect is appropriate to thought content but inappropriate to her situation.

**Speech and Language**

Speech fluent and grammatical. Decreased spontaneity of speech, with prolonged latency and pauses. Occasional word-finding difficulty. Speaks in a monotone.

**Thought Content & Process and Perception**
No suicidal or homicidal ideation. Obsessed and preoccupied with germs and fears about death or contamination of baby, but not of delusional proportions. Tangential and circumstantial. Has magical thinking about wiping baby certain way. Denies auditory hallucinations commanding her to wash; no visual or tactile hallucinations, or illusions. No ideas of reference, blocking, or looseness of associations.

**Cognition**
Is oriented to time, place, and person. Distractible, but when focused, is attentive. Appears of below average intelligence. Tendency to be concrete in thinking.

**Insight & Judgement**
Insight impaired by depressive symptoms; views world unrealistically negatively. Judgement is impaired, as evidenced by suicidality.

# Sample MSE Questions

**Sample questions to assist you when assessing children and adolescents.**
*Ref: Dr Barry Nurcombe Discipline of Psychiatry UQ School of Medicine PXMH7010 Study Guide*

## MSE: WITH THE CHILD

Has anyone told you about why you are here today?
(if yes) Who?
(if yes) What did he (she) say?

Tell me why you think you are here. (if child mentions a problem, explore it in detail)
How old are you?
When is your birthday?
Your address is ...?
And your telephone number is ...?

## SCHOOL:

Let's talk about school. What grade are you in?
What is your teacher's name?
What grades are you getting?
What subjects do you like the best?
And what subjects do you like least?
What subjects give you the most trouble?
And what subjects give you the last trouble?
What activities are you in at school?
How do you get along with your classmates?
How do you get along with your teachers?
Tell me how you spend a usual day at school?

## HOME:

Now let's talk about your home. Who lives with you at home?
Tell me a little bit about each of them.

What does your father do for work?
What does your mother do for work?

Tell me what your home is like.
Tell me about your room at home.

What chores do you do at home?

How do you get along with your father?
What does he do that you like?
What does he do that you don't like?

How do you get along with your mother?
What does she do that you like?
What does she do that you don't like?

(where relevant) How do you get along with your brothers and sisters?
What do (does) they (he/she) do that you like?
What do (does) they (he/she) do that you don't like?

Who handles the discipline at home?
Tell me about how they (he/she) handled (handles) it.

## INTERESTS:

Now let's talk about you. What hobbies and interests do you have?
What do you do in the afternoons after school?
Tell me what you usually do on Saturdays and Sundays.

## FRIENDS:

Tell me about your friends.
What do you like to do with your friends?

## MOODS/FEELINGS:

Everybody feels happy at times. What kinds of things make you feel happiest?

What are you most likely to get sad about?
What do you do when you are sad?

Everybody gets angry at times. What kinds of things make you angriest?
What do you do when you are angry?

## FEARS/WORRIES:

All children get scared sometimes about some things. What kinds of things make you feel scared?
What do you do when you are scared?

Tell me what you worry about?
Any other things?

## SELF CONCEPT:

What do you like best about yourself?
Anything else?

What do you like least about yourself?
Anything else?

Tell me about the best thing that ever happened to you.
Tell me about the worst thing that ever happened to you.

## SOMATIC CONCERNS:

Do you ever get headaches?
(if yes) Tell me about them (how often? What do you usually do?)

Do you get stomach aches?
(if yes) Tell me about them (how often? What do you usually do?)

Do you ever get any other kinds of body pains?
(if yes) Tell me about them?

## THOUGHT DISORDER:

Do you ever hear things that seem funny or unusual?
(if yes) Tell me about them (how often? How do you feel about them? What do you usually do?)

Do you ever see things that seem funny or unreal? (How often? How do you feel about
them? What do you usually do?)

## FOR ADOLESCENTS only:

Do you have a special girlfriend (boyfriend)?
(if yes) Tell me about her (him).

Do you have sexual concerns? What kinds of sexual concerns do you have?
(if present) Tell me about them.

## DRUG/ALCOHOL USE:

Do your parents drink alcohol?
(if yes) Tell me about their drinking (how much, how frequently, and where).

Do your friends drink alcohol?
(if yes) Tell me about their drinking.

Do you drink alcohol?
(if yes) Tell me about your drinking?

Do your parents use drugs?
(if yes) Tell me about the drugs they use (how much, how frequently, and where).

Do your friends use drugs?
(if yes) Tell me about the drugs they use.

Do you use drugs?
(if yes) Tell me about the drugs you use.

## MEMORIES/FANTASY:

What is the first thing you can remember from the time you were a very little baby?

Tell me about your dreams.
What dreams come back again?

Who are your favourite television characters?
Tell me about them.

What animals do you like best?
Tell me about these animals.

What animals do you like least?
Tell me about these animals.

What is your happiest memory?

What is your saddest memory?

If you could change places with anyone in the whole world, who would it be?
Tell me about that.

If you could go anywhere you wanted to right now, where would you go?
Tell me about that.

If you could have three wishes, what would they be?

What things do you think you might need to take with you if you were to go to the moon and stay there for six months?

## ASPIRATIONS:

What do you plan on doing when you become an adult?

Do you think you will have any problem doing that?

If you could do anything you wanted when you become an adult, what would it be?

## CONCLUDING QUESTIONS:

Do you have anything else that you would like to tell me about yourself?

Do you have any questions that you would like to ask me?

# Diagnostic Formulation

## Introduction

When assessing a child, adolescent and family it is important to synthesize the data into a formulation. This formulation is a concise summary of the client in light of all the information available. It is a clearly written, logical, dynamic explanation of the client, which leads to an understanding of the case, plan of treatment, management or further assessment. A formulation should be written so that it highlights the most significant factors and how these factors interplay. It is a good idea to update the formulation from time to time during the treatment process.

The *diagnostic formulation* is an integrated statement about the nature of the case. It addresses the following areas:

- Presentation
- Symptom Pattern
- Predisposition
- Precipitation
- Perpetuation
- Prognosis
- Potentials

Keep in mind that the formulation should inform your further assessment, treatment and management and assist in clarifying and prioritising the goals treatment goals.

You may like to use the formulation grid below in organising the information collected.

| | Symptom Pattern | Precipitating Factors | Predisposing Factors | Perpetuating Factors | Protective Factors |
|---|---|---|---|---|---|
| Biological/Physical | | | | | |
| Psychological | | | | | |
| Social/Familial | | | | | |

## A Brief Description of the P's:

*The following section has been directly taken from a training package developed by Tracey Stanley, Mental Health Nurse Educator, Bayside Mental Health Service.*

**Presentation**

In order to understand the presenting problems, one of the questions you will need to answer is why the child or young person is presenting at this time.
What are the client's main presenting problems?

**Symptom Pattern**

What is the symptom pattern and its meaning?
Do the current clinical features represent the overstrained coping mechanisms, or the establishment of maladaptive coping?
Do the symptoms have any communicative meaning? If so, what do they mean, and to whom are they directed?
What is the pattern of impairments? What are the weaknesses of the client or their systems?

**Predisposition**

What made the child/ young person vulnerable to developing the problems at this time?
Are there biological, psychological and social factors in the child/ young person or family which predispose to the development of the disorder?
Constitutional (including genetic) factors, temperamental, and environmental factors should each be considered. These may include physical or psychosocial issues around conception or which have affected the child in the uterus or in early life.

**Precipitation**

If the problem has an onset, what triggered or aggravated it?
What has precipitated this presentation?
Does the onset of the child/ young person's presentation suggest a recent precipitating factor, or has the current pattern evolved imperceptibly from early vulnerability?
What has lead to a change in the child/ young person/ family's usual coping factors?
Why did the precipitation factor, or factors, lead to coping failure?
Were the child/ young person/ family's coping mechanisms over-whelmed by the sheer enormity of the stress, or was the stress idiosyncratic and derived from specific predisposition?

**Perpetuation**

What keeps the problem going? What factors are maintaining the child's difficulties?
What are the barriers to resolution of the problem?
Do the perpetuating factors represent a continuation or extension of the predisposing or precipitating factors?

**Potentials**

This may be a separate category, but for our purposes can be included as part of the pattern of coping.
What are the biological, psychological and social resources and strengths of the child/ young person and family?
These are the factors which develop resiliency in the individual, limit the severity of the disorder and assist in healthy functioning.
They include support systems, personality strengths, coping skills, friendships, general health, safety and security.

**Prognosis**
Prognosis refers to the likely outcome for the child/ young person, with or without treatment. It is not generally necessary to include this information, but there may be circumstances where it is useful to include, for example if there are issues related to participation or engagement in treatment.

## Example of How to Write a Formulation

*The following section has been directly taken from a training package developed by Tracey Stanley, Mental Health Nurse Educator, Bayside Mental Health Service.*

The next step is to develop a narrative summary which describes the relationship between relevant factors. The following outlines the steps involved in integrating the information from the formulation grid into narrative form.

### 1. Demographic Information:

The narrative should begin with the demographic information:

- Name
- Gender
- Age in years and months
- School attended and year
- Lives with: family constellation, housing and income.

An example is as follows:

***Lachlan is a six years, ten months old boy who has commenced year one at Wilsonton State School this year. Lachlan lives with his parents, Kate and Michael, and Michael's 20 year old daughter from a previous marriage. Kate commenced work as research assistant this year and Michael operates an independent IT consultancy.***

### 2. Referral Description:

Who referred the child/ young person and when:

*Lachlan is a six year, ten month old boy who has commenced year one at Wilsonton State School this year. Lachlan lives with his parents, Kate and Michael, and Michael's 20 year old daughter from a previous marriage. Kate commenced work as research assistant this year and Michael operates an independent IT consultancy.*

***The family Dr, Wendy Smythe has referred Lachlan in May of this year...***

### 3. Presented Problem:

**Refer to Presentation and Pattern**
A brief outline of the problems the child is being referred for / presenting with.
If a diagnosis has previously been made this can be included.
The context or background in which the presenting factors are occurring.

*Lachlan is a six year, ten month old boy who has commenced year one at Wilsonton State School this year. Lachlan lives with his parents, Kate and Michael, and Michael's 20 year old daughter from a previous marriage. Kate commenced work as research assistant this year and Michael operates an independent IT consultancy.*

*The family Dr, Wendy Smythe has referred Lachlan in May of this year* ***for anxiety related to school attendance. Lachlan is experiencing frequent headaches and tummy aches which cause him to miss school up to two or three days a week. Medical investigations have not revealed a physical basis for these symptoms, however, Lachlan experienced life-threatening respiratory and gastro-intestinal problems as a neonate, and continued to have frequent respiratory infections. As a result of these health problems, he has had limited experience of child care outside the home, and attended preschool for only half-days. His general health and development is now progressing well...***

## 4. Precipitating Factors:

**Refer to Precipitants**
Identify the precipitating event (s)/ stressors:

*Lachlan is a six year, ten month old boy who has commenced year one at Wilsonton State School this year. Lachlan lives with his parents, Kate and Michael, and Michael's 20 year old daughter from a previous marriage. Kate commenced work as research assistant this year and Michael operates an independent IT consultancy.*
*The family Dr, Wendy Smythe has referred Lachlan in May of this year for anxiety related to school attendance. Lachlan is experiencing frequent headaches and tummy aches which cause him to miss school up to two or three times a week. Medical investigations have not revealed a physical basis for these symptoms, however Lachlan experienced life-threatening respiratory and gastro-intestinal problems as a neonate, and continued to have frequent respiratory infections. As a result of these health problems, he has had limited experience of child care outside the home, and attended preschool for only half-days. His general health and development is now progressing well,* ***however his current symptoms appear to be precipitated by his commencement at school full-time coinciding with his mother's return to full-time work.***

## 5. Perpetuating Factors (Acute and Chronic)

**Refer to Perpetuation**
Eg...."*This is the first time in an otherwise well functioning boy/ family", "There is a long history of such problems", "Starting from"…….*

*Lachlan is a six year, ten month old boy who has commenced year one at Wilsonton State School this year. Lachlan lives with his parents, Kate and Michael, and Michael's 20 year old daughter from a previous marriage. Kate commenced work as research assistant this year and Michael operates an independent IT consultancy.*
*The family Dr, Wendy Smythe has referred Lachlan in May of this year for anxiety related to school attendance. Lachlan is experiencing frequent headaches and tummy aches which cause him to miss school up to two or three times a week. Medical investigations have not revealed a physical basis for these symptoms; however Lachlan experienced life-threatening respiratory and gastro-intestinal problems as a neonate, and continued to have frequent respiratory infections. As a result of these health problems, he has had limited experience of child care outside the home, and attended preschool for only half-days. His general health and development is now progressing well, however his current symptoms appear to be precipitated by his commencement at school full-time coinciding with his mother's return to full-time work.* ***The history is suggestive of long standing mild anxiety of both mother and child related to Lachlan's early health problems.***

## 6. Predisposing Factors:

What biological, psychological or social factors predisposed the development of the disorder?

*Lachlan is a six year, ten month old boy who has commenced year one at Wilsonton State School this year. Lachlan lives with his parents, Kate and Michael, and Michael's 20 year old daughter from a previous marriage. Kate commenced work as research assistant this year and Michael operates an independent IT consultancy.*
*The family Dr, Wendy Smythe has referred Lachlan in May of this year for anxiety related to school attendance. Lachlan is experiencing frequent headaches and tummy aches which cause him to miss school up to two or three times a week. Medical investigations have not revealed a physical basis for these symptoms, however Lachlan experienced life-threatening respiratory and gastro-intestinal problems as a neonate, and continued to have frequent respiratory infections. As a result of these health problems, he has had limited experience of child care outside the home, and attended preschool for only half-days. His general health and development is now progressing well, however his current symptoms appear to be precipitated by his commencement at school full-time coinciding with his mother's return to full-time work.*
***The history is suggestive of long standing anxiety of both mother and child related to Lachlan's earlier health problems. Kate has a history of anxiety which is generally well managed; however she has difficulty managing her anxiety at times of significant adjustment. Maternal grandmother also experiences social anxiety and probably has suffered anxiety and depression in the past. She reports a "breakdown" following the loss of Kate's older brother as a newborn. There is a no further family history of mental health disorders in the family.***

## 7. Causal Hypothesis:

**Describe the interaction of factors, ie how they relate to each other**
Eg, *"This would represent the following dynamics / pattern of interaction"....*

*Lachlan is a six year, ten month old boy who has commenced year one at Wilsonton State School this year. Lachlan lives with his parents, Kate and Michael, and Michael's 20 year old daughter from a previous marriage. Kate commenced work as research assistant this year and Michael operates an independent IT consultancy.*
*The family Dr, Wendy Smythe has referred Lachlan in May of this year for anxiety related to school attendance. Lachlan is experiencing frequent headaches and tummy aches which cause him to miss school up to two or three times a week. Medical investigations have not revealed a physical basis for these symptoms; however Lachlan experienced life-threatening respiratory and gastro-intestinal problems as a neonate, and continued to have frequent respiratory infections. As a result of these health problems, he has had limited experience of child care outside the home, and attended preschool for only half-days. His general health and development is now progressing well, however his current symptoms appear to be precipitated by his commencement at school full-time coinciding with his mother's return to full-time work.*

*The history is suggestive of long standing anxiety of both mother and child related to Lachlan's earlier health problems. Kate has a history of anxiety which is generally well managed; however she has difficulty managing her anxiety at times of significant adjustment. Maternal grandmother also experiences social anxiety and probably has suffered anxiety and depression in the past. She reports a "breakdown" following the loss of Kate's older brother as a newborn. There is a no further family history of mental health disorders in the family.*

***Lachlan's health problems are now well managed with his current medical regime, and his family recognise and treat potential respiratory problems early. Kate is looking forward to progressing her career, however the established patterns of anxiety in both mother and child appear to be impeding progress for both.***

## 8. Judgement about Severity of Problem:

**Refer to Potentials and Prognosis**
Is the current episode an isolated incident or temporary developmental crisis?
What family/ social/ educational/ community factors, strengths and potential impact on prognosis?
What are the risks?

*Lachlan is a six year, ten month old boy who has commenced year one at Wilsonton State School this year. Lachlan lives with his parents, Kate and Michael, and Michael's 20 year old daughter from a previous marriage. Kate commenced work as research assistant this year and Michael operates an independent IT consultancy.*
*The family Dr, Wendy Smythe has referred Lachlan in May of this year for anxiety related to school attendance. Lachlan is experiencing frequent headaches and tummy aches which cause him to miss school up to two or three times a week. Medical investigations have not revealed a physical basis for these symptoms, however Lachlan experienced life-threatening respiratory and gastro-intestinal problems as a neonate, and continued to have frequent respiratory infections. As a result of these health problems, he has had limited experience of child care outside the home, and attended preschool for only half-days. His general health and development is now progressing well, however his current symptoms appear to be precipitated by his commencement at school full-time coinciding with his mother's return to full-time work.*

*The history is suggestive of long standing anxiety of both mother and child related to Lachlan's earlier health problems. Kate has a history of anxiety which is generally well managed, however she has difficulty managing her anxiety at times of significant adjustment. Maternal grandmother also experiences social anxiety and probably has suffered anxiety and depression in the past. She reports a "breakdown" following the loss of Kate's older brother as a newborn. There is a no further family history of mental health disorders in the family.*

***Lachlan's health problems are now well managed with his current medical regime, and his family recognise and treat potential respiratory problems early. Kate is looking forward to progressing her career, however the established patterns of anxiety in both mother and child appear to be impeding progress for both. Generally, he is developing well and his father and step-sister are involved in his care and supportive of the changes in family life occurring at this time.***

***The family and school are developing strategies to support and encourage Lachlan in his emotional and social development. With timely treatment of Lachlan's anxiety and Kate's responses, it is likely that the current episode can be resolved, although Lachlan may become vulnerable at other points of developmental change or stressful periods during his life.***

# Treatment / Recovery Planning

### Introduction

Recovery planning is essential to retain clarity for all parties involved in treatment. Recovery plans are ideally developed in collaboration with the client, carer and the Case Manager. A copy should be provided to the client and with the client's permission, other involved services (eg: drug and alcohol, school support services) should also be given a copy.

This enables a clear delineation of roles to exist and promotes a cohesive provision of service. A Recovery Plan, as Dr Scott says in DVD 2, helps the clinician avoid 'therapeutic drift'. A Recovery Plan should be completed immediately after or alongside the completion of the initial assessment and should be presented with the assessment at the initial client case review team meeting.

### Recovery Plan Forms

For CYMHS approved forms on which to write up the recovery plan see the section entitled 'Forms' for the Queensland Health approved form template for Recovery Plans. These include:

- Recovery Plan (Individual Care/Treatment Plan & Relapse Prevention Plan)
- Consumer Care Review Summary
- Consumer End of Episode/ Discharge Summary

### Recovery Plan reference DVDs

1. Description of what to include in a recovery plan seen in DVD 2 by Dr James Scott
2. Demonstration of what to include in a safety plan – a component of treatment planning seen in DVD 5 by Matthew Parkyn (Psychologist)

### Helpful Tools in Recovery Planning

1. Sample Recovery Plan seen in Case Study example in Unit 2.1 for DVD 2 - Recovery Plan for Jarryd
2. The forms themselves provide helpful points to pay attention to. These include:
    a. The starting date for treatment of the identified problem
    b. Identifying the particular problem/ issue to be addressed
    c. Describing the goal of treatment for that problem in specific ways so that success can be measured
    d. List clear strategies that the client and therapist agree on that both the client feels comfortable with and the therapist can provide or access that may help the goal be achieved
    e. Identify the people or services that will need to be involved to implement the strategies and achieve the goals
    f. Suggested dates for review – assist staying on track and providing opportunities for changing direction of necessary
    g. Listing the outcomes is encouraging for clients, carers and case managers and reinforces forward progress
    h. End dates provide closure points and complete the process

# Unit 2.2
# Introduction to Mental State Examination, Formulation and Treatment Planning

Additional Learning Materials

# Additional Learning Materials

*Adapted from: CYMHS Inpatient Training Program – Mental State Assessment. Developed by Matthew Cartwright, Senior Project Officer, CYMHS.*

## Mental State Examination

A Mental State Examination (MSE) is a systematic approach to assessing and evaluating an individual's mental state at a specific point in time, and involves the consideration of the individual's physical, cognitive and emotional characteristics. The aim of the MSE is to clarify the nature of the individual's mental health problems, assess current mental state, identify early warning signs for relapse, and to provide a baseline of functioning to use as a comparison. An MSE is usually completed during the initial interview. Subsequently, clinician's informally assess and observe a client's Mental State on an ongoing basis. A formal MSE may also be necessitated by a change in clinical presentation, prior to revoking an ITO (Involuntary Treatment Order) or Forensic Order, and prior to discharge and at follow-up post discharge.

## Overview of the Mental Status Examination

The following areas are examined in the MSE:

- Appearance
- Behaviour and Motor Activity
- Speech (Rate, Volume, Quantity)
- Mood and Affect
- Relationship with examiner
- Thought Form
- Thought Content
- Perception
- Cognitive Functioning
  - Orientation (Time, place and person)
  - Attention/Concentration
  - Memory
  - Abstract Thinking
- Insight
- Judgement
- Capacity for, and thematic content of, fantasy

The following outline gives you an example of areas to consider when assessing mental state for the child and the adolescent. Note the differences in the mental state and how the information is ascertained. Remember, plan to develop competence in the area of assessment you have identified as a learning need.


For each category of the mental state examination below, there are a number of prompts to assist you to assess the patient comprehensively. Think critically what the data might reflect about the child and the family. Eg in appearance the child looks thin, dirty and mildly dishevelled.

## Mental State Examination: Child or Adolescent

1. **Appearance**
   - Describe the individuals physical appearance
     - Gender, height, weight, apparent age, physical maturation, nutrition, body type and physique, skin, hair, facial features, grooming, hygiene, clothing, tattoos, physical abnormalities, distinguishing/significant features

2. **Behaviour**
   - Describe the individual's motor behaviour
     - Activity level, posture, restless, repetitive behaviours, hyperactive, tremors, posture, gait, balance, coordination, power, tone, abnormal movements, startle response, mannerisms, habits, rituals, stereotyped movements

3. **Voice, Speech and Language**
   - Rate: slow, rapid, rapid, pressured (rapid, difficult to interpret, loud).
   - Volume: Monotonous, loud, quiet, soft, normal, shouting
   - Quantity of information: Nil spontaneous, normal, talkative, or garrulous, poverty of speech (restricted speech, replies brief), mutism (total absence of speech).
   - Quality (accent, rhythm, impediments, vocabulary, articulation)
   - Other considerations: Amplitude, pitch, tone, tempo, prosody, phonation, rhythm, fluency, comprehension, conversational ability, syntax, use of gesture

4. **Relationship with Examiner**
   - Describe the individual's reaction to the present situation and the examiner
     - hostile, friendly, withdrawn, guarded, cooperative, uncommunicative, seductive, childish, silly, dependent, evasive, anxious, hostile, fearful, suspicious, indifferent, suggestibility, dramatism, eye contact, degree of rapport

5. **Affect and Mood**
   - Mood refers to the internal feeling or emotion that influences behaviour and one's perception of the world
     - Predominant mood : Depressed, euthymic (normal) anxious, irritable, angry, apathetic, euphoric, elevated, flat, guilty, suspicious, fearful, hostile

- Affect refers to the one's external emotional response and outward expression of how they feel
  - Congruity of Affect - Note whether their emotional response is appropriate for the subject matter
  - Range of Affect - Normal, restricted (decrease in intensity and range), blunted (severe decrease in intensity and range), flat (total or near absence of emotional expression), labile (alternating between extremes)
  - Control of affect/appropriateness

6. **Thought Form and Process**

Assessed according to:

- Amount of thought and rate of production/fluency
  - flight of ideas (difficulty expressing thoughts as quickly as they come to mind), poverty of ideas (lack of thoughts), slow or hesitant thinking.
- Continuity of ideas
  - Refers to logical order of ideas, ability to stick to the topic. Slowing, acceleration, goal-direction, tangentiality (irrelevant/oblique answers to questions), loosening of associations, distractible speech (repeated changes in topic), irrelevance, circumstantiality (speech indirect and delayed in reaching goal idea), derailment (logical progression of thoughts shifting from unrelated and unconnected ideas), perseveration (persistent repetition), echolalia (repetition of other people's words/phrases) and thought blocking (abrupt interruption to flow of thinking).
- Disturbances in language
  - Includes the use of words that do not exist (neologism or word approximations) or conversations that do not make sense (incoherence, word salad)

7. **Thought Content**

- Refers to obsessions, compulsions, delusions, phobias, flashbacks (intrusive traumatic imagery), ideas of reference, abnormality of general or special sensation, abnormality of body image, distortion of the sense of time, confabulation, fabrication, preoccupation with identity, physical health, mental health, personal competence, or the past or future.

8. **Perception**

- Refers to hallucinations, illusions, depersonalisation, derealization,

9. ***Risk Assessment***

  - suicidal ideation
  - impulses to harm self
  - impulses to harm others
  - impulses to take risks

10. **Brief Screen for Cognitive Functioning** (refer to a Mini Mental State Examination (MMSE) for ways to assess cognitive functioning)
    - Orientation (Time, place and person)
    - Concentration
    - Memory
        - Immediate
        - Recent (Short-term)
        - Remote (Long-term)
    - Estimated Intelligence

11. **Fantasy**
    - Dreams, wishes, drawings, free play: productivity, themes, and capacity to distinguish fantasy from reality

12. **Concept of Self**
    - Dreams, wishes, drawings, free play: coherence, concepts of personal intelligence, strength, attractiveness, and relationship with others

13. **Insight and Desire for Help**
    - An awareness of their illness/problem and it effects and implications e.g. good, partial or poor. Desire for help and compliance with treatment.

**Important point to remember:** Given that children have limited verbal capacity in comparison to adolescents and adults it is appropriate during the interview that you attempt to engage the child into something they find safe, eg: play, drawing, use of puppets, dolls house, movement toys, age appropriate games etc.

Direct observation of the child in play and interpersonal interaction is important. This data will support or discount what has been reported or highlight a more detailed description of the emotion and behaviour.

Important behaviours to observe and assess in the interview are the child's motivation, responses to separation from parent/carer, response to direction, limit setting, impulse control, level of agitation or irritability and problem solving ability. During the non-structured interview and general observation of the child will provide you with useful information.

Information obtained through your observations and MSE can help to answer questions such as:

- What is the financial situation at home?
- Is the boy neglected?
- What is the child's health status, when was it checked last?
- What are the parenting skills like?
- What are the parent-child interactions like?
- What is happening in the home situation?
- Does the child look different physically from other children of his age, culture etc?

# Questions

What is a Mental State Examination?

Why do we conduct Mental State Examinations?

When would you conduct a Mental State Examination?

What factors can affect an examiner's Mental State Examination of an examinee?

What is the difference between mood and affect? How might an examiner evaluate these areas?

Are there any areas in the Mental State Examination that you are unclear about? Do you need any of the terminology clarified? Write your questions below and consult an experienced team member, your supervisor or team leader.

## Exercise

Think of a specific client whom you have recently completed an initial assessment with. Use the above headings to write up a Mental State Examination.

# Diagnostic Formulation

One way of formulating the information involves the use of the formulation matrix below. It requires the clinician to deconstruct information gained in the assessment and reorganise into bio-psycho-social parameters, highlighting presenting, predisposing, precipitating, perpetuating factors, the patterns, potentials and prognosis (the 7 P's).


Think of a specific assessment that you have recently completed on a client. Use the following template to develop your formulation.

Brief Description of Current Problems:

| | Symptom Pattern | Precipitating Factors | Predisposing Factors | Perpetuating Factors | Protective Factors |
|---|---|---|---|---|---|
| Biological/Physical | | | | | |
| Psychological | | | | | |
| Social/Familial | | | | | |

# Treatment Planning

Based on your assessment information and formulation, and in collaboration with the client and their parents, a treatment plan can be developed. The purpose of the treatment plan is to determine the focus of treatment, and to clearly stipulate the presenting problems, goals and objectives of treatment, intervention strategies and to determine time frames. The treatment plan needs to be updated on a regular basis to reflect changes in the target areas, goals, objectives, or treatment. The treatment plan ensures that therapy has a degree of structure and focus and that the relevant parties agree with the focus of therapy. It assists the therapist to consider the most appropriate intervention strategies, and provides an avenue for reviewing progress and outcomes. The components of treatment planning include:

**1. Problem/Issue**

Refers to the most significant problems which will be the focus of treatment. This will be based on the data gathered in the assessment process, and will consider the client's prioritisation of issues. An effective treatment plan may only deal with a few selected problems, to ensure that treatment does not lose direction.

**2. Goals**

Indicates what the clinician and client is hoping to achieve in regards to the problem/issue.

**3. Intervention/Strategy/Activity**

Clinician selects an appropriate therapy or intervention technique in collaboration with the client to address the problem and achieve the goals. The choice of intervention is based on empirical evidence, resource availability (time, resources), risk, appropriateness for client/family and the clinician's style/skill. It is important that the clinician continually monitor the effectiveness of the treatment and the patient's response, and alter the treatment plan as required. If a client has not achieved their goal after implementation of the intervention, then the treatment plan will need to be revised.

**4. Person Responsible**

The name of the person/s responsible for implementing the intervention strategy and monitoring the intervention effectiveness and patient's progress. Typically this is the client themselves, the clinician, family, guidance officer, other professionals etc.

**5. Review Date**

Date when the clinician and client/family will review the treatment plan and progress, and determine whether any changes are required.

**6. End Date**

Date when objective has been achieved and when that particular goal is no longer the focus of treatment.

# Unit 2.2

# Introduction to Mental State Examination, Formulation and Treatment Planning

Record of Learning

# Record of Learning

The following activities are suggestions for assessing your learning from this unit. They may be used as a self assessment tool or be reviewed with your team leader or supervisor.

**Suggested Learning Activities**

1. Watch “DVD 2: The Assessment and Management of Mental Health Problems in Children and Adolescents”. Complete a Mental State Examination on the child in the
2. DVD, as well as completing a formulation and treatment plan.

3. Complete the self-directed MSE, Formulation and Treatment planning (Unit 2.2) learning package and discuss answers with supervisor/team leader

4. Provide several Mental State Examinations that you have completed on clients to your supervisor/team leader to discuss and review

5. Bring 2 completed assessments to your supervisor and work collaboratively to develop a formulation and treatment plan

6. Utilise the information in this package to guide you in developing formulations on your clients. Bring copies of your formulations to your supervisor/team leader to discuss and review.

7. Based on your assessment and formulation, develop treatment plans for clients with different presenting problems. Bring these treatment plans to your supervisor/team leader to discuss and review.

## Record of Learning

Unit 2.2 - Introduction to Mental State Examinations, Formulations and Treatment Planning

Name of Clinician: _____

| Record of Learning | Date Achieved | Signed |
|---|---|---|
| **Mental State Examination** | | |
| Demonstrate a sound theoretical knowledge and understanding of the components of a Mental State Examination including appearance, behaviour, speech, affect and mood, attitude, thought processes, thought content, perception cognitive functioning, fantasy, concept of self, insight and judgement | | |
| Demonstrate an ability to complete a Mental State Examination utilising the appropriate terminology to describe presentation and symptomatology of a child or adolescent | | |
| Mental State Examinations capture essential information and psychopathology | | |
| **Formulation** | | |
| Demonstrates ability to write a formulation as a concise summary of the presenting problem, predisposing factors, precipitating factors, pattern/coping style, perpetuating factors, potentials and prognosis. | | |
| Formulation demonstrates an understanding of the clients presentation through a comprehensive and logical explanation of the case | | |
| Formulation encompasses the key assessment information and collateral data | | |
| Formulation is utilised to inform diagnosis and assist in the development of a treatment plan | | |
| **Treatment Planning** | | |
| Treatment plan is guided by the assessment information, diagnosis and formulation | | |
| Treatment plan is developed in collaboration with client and identifies the problem, goals, intervention strategy, person responsible and time frames. | | |
| Formulation is utilised to inform diagnosis and assist in the development of a treatment plan | | |

Additional Supervisor/ Team Leader feedback and comments:

Signature _____


Congratulations and well done for completing this unit of learning. We hope it has been useful and interesting.


Please now complete and return the evaluation/ feedback forms. There is a form for you as the clinician and one for your supervisor to complete. Both of these forms are found in the section 'Evaluation/ Feedback Forms at end of this package.

Thank you