Assessing Mental State "Looking, Listening & Asking"

By **Paul McNamara** @meta4RN
RGN (RAH), RPN (SAMHS), BN (Flin.), MMHN (USQ), Cert IMH (WCHN), CMHN, FACMHN

Adapted from the original work of **Jenni Bryant** @JenCLNinja
RN, RPN (NPC) RGN (BDH), MRN(MH), BN(UNE), MN (Research) (UoN), FACMHN

Every Australian undergraduate nurse is introduced to mental health and undertaking mental state examinations/assessments. However, only about one in every twenty nurses will specialise in working in mental health. For the majority of nurses (ie: those not working in mental health) undertaking a mental state assessment can often become a forgotten skill. This, in turn, deskills the nurse and disadvantages the patient – it's not holistic care if mental health isn't considered along with the medical/surgical/maternal aspects of care. As the adage says: there is no health without mental health.

If you're not accustomed to incorporating mental state examinations (MSE) into your everyday role, it can feel a bit intimidating. Nurses I've worked with sometimes feel that they're not adequately equipped to assess someone's mental state. Of course they are – as long as they have a bit of emotional intelligence (self-awareness, self-regulation, social skills, empathy and motivation), and break down mental state examination to the three core skills that Jenni Bryant identified in her original powerpoint presentation: looking, listening and asking (adapted, online version available via meta**4RN**.com/MSE).

This online version is in response to a few people requesting to have a print-friendly version, and/or something they'll always have "in their pocket", via internet-connected smartphones. The meta**4RN**.com website readily acknowledges that .edu and .gov websites have more credibility. However, many of those websites are not device-agnostic, so don't render as well as meta**4RN**.com does on smartphones and tablets.

It's a good habit to document a brief MSE for all your patients, not just those with a diagnosed mental illness. Mental state can and does change over a shift, day or week – it's important to notice and communicate changes.

A comprehensive mental state assessment will include a full history: medical history, psychiatric history, medication history and personal history (developmental, relationship, education, employment, social). As history is static, there is no need to make this part of your "everyday" regular MSE.

A MSE is a snapshot as the person as they are at the time. A well-documented MSE conveys this impression for the reader. Using non-judgemental language, direct quotes of what the person says, and finding the right descriptors/adjectives makes for good MSE documentation. No need to worry about sentence construction. Dot points are fine.

Hopefully the following info will assist.

Assessing Mental State "Looking, Listening & Asking"

General Description (Looking)

Level of Consciousness

- drowsy, alert, sleeping, fluctuating

Appearance

- grooming, makeup, posture, clothing, obvious physical deformities or characteristics

Behaviour

- eye contact, rapport, level of activity (do you see psychomotor agitation or psychomotor retardation? if so, describe it), body language, mannerisms, specific activities

Speech (Listening)

Physical qualities

Flow

- smooth, hesitant, interrupted, staccato
- easy to interrupt/redirect?
- are responses prompt or delayed?

Rate

- fast (pressured), slow, or unremarkable?

Volume

- soft, loud/pressured, unremarkable.

Tone

- flat, monotonous, restricted range, expressive

Continuity

- the capacity to maintain a normal progression from one stream of thought to the next: over-inclusive, poverty, circumstantial, perservation or blocking?

Form

- assess for abnormalities of form of speech, not form of thought eg stammer/stutter, dysarthia, expressive or receptive aphasia.

Clarity

Accent

Affect (Looking)

An objective assessment of facial and bodily expression of mood state.

- Is affect appropriate to content? (congruent)
- Assess the range, appropriateness, intensity and quality of affect
- Rapid shift from one emotive response to another? (lability)

Some Useful Adjectives:

sad, tearful, angry, irritable, elated, euphoric, frightened, despondent, animated, expansive, cooperative, ingratiating, distressed, discouraged, anxious, hostile, guarded, anxious, calm, ambivalent, dysphoric, euthymic, suspicious, fatuous, bewildered, perplexed

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Mood (Asking)

A subjective assessment of mood state.

- How has your mood been lately?
- How do you feel within yourself?
- What has given you happiness, joy or enjoyment recently?
- Are you a good person?
- Have you been feeling guilty or sad?
- If 10 is as good as you ever feel and 0 is as low as you go, where on the scale have you been over the last couple of weeks?

Neurovegetative signs and symptoms:

Sleep, Appetite, Irritability, Tearfulness, Energy, Motivation, Libido, Withdrawal

Thoughts (Asking & Listening)

Form

- coherent? rational? sequential/linear?
- amount - poverty, flight of ideas, vague
- continuity of ideas - incoherent, blocking, circumstantial, tangential, irrelevant
- disturbance in meaning or use of language - neologisms, word salad

Content

- delusions, obsessions, compulsions, suicidal ideation, phobias, paranoia, preoccupations?
- Do you feel safe here/at home?
- Are you able to project your thoughts onto others?
- Are other people able to insert ideas/thoughts into your head?

Perception (Looking, Listening & Asking)

Hallucinations = false sensory perception that occurs in the absence of a stimulus. Can affect any of the senses: auditory, visual, olfactory, tactile, gustatory

- Have you been experiencing any unusual sensations that you can't easily explain?
- Do you any special powers?
- Sometimes when people are really stressed they hear voices/noises, but there's nobody there. Has that ever happened to you?
- You seem distracted by something I can't see. Can you help me understand what you're experiencing?

Ideas/delusions of reference

- Do you have any unusual experiences when watching TV, or listening to music?
- Do you ever feel that the TV has special messages just for you?

Illusion = misinterpretation of sensory stimulus

- eg: responding to a pyjama top on a chair as if it were a cat; being startled by something out the corner of their eye.

Cognition (Asking & Listening)

Orientation

- time, place, person, situation

Memory

Concentration

Attention

Clock Drawing Test [brief frontal lobe assessment]

- please draw a large circle, then insert numbers to make it look like a clock.
- now draw in the hands to show ten past eleven

MMSE: Mini Mental State Examination

- screening [ie: not diagnostic] tool for cognitive impairment - best for mild to moderate
- does not differentiate between delirium and dementia
- used to detect impairment, to follow course of illness, to monitor treatment response
- affected by education, intelligence, age, literacy, culture and inter-rater reliability

MMSE alternatives include:

- MoCA: Montreal Cognitive Assessment
- ACE-R: Addenbrooke's Cognitive Examination
- RUDAS: Rowland Universal Dementia Assessment Scale
- KICA: Kimberley Indigenous Cognitive Assessment

Insight & Judgement (Asking & Listening)

Insight =

- Does the person recognise symptoms (eg: confusion, hallucinations) as symptoms?
- Is the person aware that they are ill and understand the effects and implications?
- Is the person seeking assistance/information or rejecting help?
- Good, partial or poor? As evidenced by…

Risk (Asking & Listening)

Estimation of risk will be influenced by the person's history (ie: previous experiences, behaviours and exposures) – the static factors.

Risk is best explored after rapport has been established, and the person knows that you are a safe, non-judgemental person. If somebody discloses intent/plans of harming themselves or others, thank them for trusting you, and let them know that it is too important a matter for just the two of you to handle alone. You'll arrange for support.

The suggested questions below are for dynamic, "here and now", factors only

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Risk to Self

- Do you still have "the fighting spirit"?
- Do you ever think, "what's the point in going on?"
- What's keeping you going?, what makes life worth living?
- Have you thought you would be better off dead? How strong are these thoughts?
- Have you thought of suicide?
- Have you made a plan? [if "yes", does the person have access to means?]
- When would you do this?
- What can I do to help you to stay safe?

Risk to Others

- You seem pretty angry.
- Are you able to express that anger safely?
- Do you feel like acting on that anger?
- Do you feel like hurting someone?
- Are you safe to be around at the moment?
- Am I safe with you? What about the other staff and patients here?
- What can I do to help you to stay safe?

Alcohol, Tobacco & Other Drugs (Asking & Listening)

Most substance abuse is contextual

Give "permission" for honest answers

- "Sounds like you've had a lot of stress lately. How have you been coping?"
- "You've got a lot of stuff going on at the moment… are you drinking or smoking more than usual?"
- "In FNQ plenty of people use the bottle shop or a bit of choof or speed to try to manage stress. How about you?"

Quantity. Frequency. Recency. Route.

Substances:

- Alcohol
- Tobacco
- Cannabis (choof, gunja, yarndi, weed, dope)
- Amphetamines (speed, goey)
- Methamphetamines (ice, crystal meth)
- MDMA = methylenedioxymethamphetamine (ecstasy)
- Opioids (codeine, morphine, methadone, heroin)
- Benzodiazepines (benzos: diazepam, oxazepam, nitrazepam/moggies, temazepam/normies, alprazolam/xannies)
- Hallucinogens (LSD, magic mushrooms)