

Understanding the Mental State Examination (MSE): a basic training guide



Developed by the Perth Co-occurring Disorders Capacity
Building Project Consortium (Non-Residential)

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Legal Disclaimer

This DVD and booklet are a guide only, based on evidence-based information available at the time of publication. The DVD is designed to assist clinical practice and assessment and is to be followed together with a clinician's judgement in each individual case.

Foreword

On behalf of the Perth Co-occurring Disorders Capacity Building Project (PCDCBP) Consortium, I have pleasure in presenting the DVD, *Understanding the Mental State Examination (MSE): a basic training guide*. This resource has been designed to strengthen the capacity of alcohol and other drug (AOD) clinicians in completing a baseline Mental State Examination (MSE) with their clients. The DVD has been designed using visual case study scenarios, and is accompanied by this instructional training booklet, to help clinicians test their skills in completing an MSE. The overall purpose of the DVD is to introduce clinicians to the MSE assessment tool with the view that more comprehensive training on the MSE be completed in the future.

Although designed primarily for the AOD sector, trainers and clinicians working in the mental health field may find this resource useful. Many experienced mental health and alcohol and other drug professionals were involved in the development of this resource, producing a training tool that can be used by any clinician who needs to screen clients for the presence of mental health issues.

A considerable amount of time and effort has been put into the development of the DVD and booklet. For this, I would like to thank all the project staff, consultants, clinicians and consumers, who contributed to the development of the DVD and booklet and provided feedback during the 'road testing' of the resource. Having so many people

involved in the project meant that many valuable partnerships were formed, especially between AOD agencies and mental health service providers. The final product demonstrates how collaborative partnerships between both sectors can result in the development and delivery of quality service improvement initiatives.

I would also like to thank and acknowledge the support and advice from consortium members in the conceptual and developmental stages of this training resource. This has been an important undertaking by the Consortium.

In closing, the consortium members anticipate that the AOD and mental health sectors will find this resource useful in providing their staff with baseline MSE training. Having a better skilled workforce who work very often with clients presenting to AOD services with mental health symptoms will no doubt contribute to the delivery of improved services to our clients.

Sheila McHale
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(lead agency for the PCDCBP Consortium)

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1 Introduction

Purpose

The intention of this Mental State Examination (MSE) DVD and accompanying booklet is to assist alcohol and other drug (AOD) clinicians to be more confident in completing a baseline MSE on their clients. The DVD has been designed to be an introductory instructional training tool on the baseline MSE. It is recommended that AOD clinicians seek additional comprehensive training on the MSE to be clinically competent in the assessment tool.

The DVD contains three visual case study scenarios which clinicians can use to test their knowledge and skills in conducting an MSE. *Firstly however, it is strongly recommended that clinicians read sections 1, 2 and 3 of this instructional booklet before watching the DVD.* Where guided to do so on page 22, please download the relevant forms from the internet. You will need these to assist you in carrying out an MSE on the visual case study scenarios.

The following pages briefly define the MSE and the domains of this mental health assessment tool. Further information on mental health

conditions and assessments can be accessed from the *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*¹

<http://www.med.unsw.edu.au/NDARCWeb.nsf/page/Comorbidity+Guidelines>

What is a Mental State Examination?

A Mental State Examination (MSE) is the process of assessing an individual's mental state and behaviour at the time of an interview. It uses a common format and language to record information, which can be readily understood across different services. The goal is to identify signs and symptoms of mental illness to ensure appropriate assistance can be given to the client and that any risks are addressed. The MSE can be brief or more thorough depending on the circumstances (i.e. in an emergency it would be brief) and can be repeated during the period of a client's treatment to observe changes over time.


What is meant by a baseline Mental State Examination?

This DVD and booklet present a pared down version of the MSE, which we have called a baseline MSE. AOD clinicians need to be able to assess a client's mental state sufficiently to be able to identify a mental health issue, especially in terms of any immediate risk issues for the client or others. Further training would be needed to carry out a comprehensive MSE. Diagnosis and treatment of co-occurring (or comorbid) mental health issues remain the realm of qualified mental health professionals.

The AOD clinician also needs to be able to discern if the client is suitable for ongoing treatment at the AOD service without specialist mental health intervention, or if there is a need to refer the client for a more thorough MSE and possible medical, psychiatric or psychological intervention.

Why do AOD clinicians need to know how to do a baseline Mental State Examination?

A high prevalence of comorbidity among clients of AOD services means that agency clinicians are frequently faced with the need to manage very complex mental health symptoms and/or problems, which can interfere with the clinician's ability to treat a client's AOD use effectively. In view of this, it becomes very important that AOD clinicians have the knowledge and skills to identify mental health symptoms, and in turn are skilled in how to manage the symptoms. The MSE is one tool used in mental health settings to screen for mental health symptoms. Training AOD clinicians in the baseline MSE will enable them to feel more confident in identifying mental health disorders/issues. Once identified, mental health disorders/issues can be more appropriately addressed through other assessments and/or referrals to qualified mental health professionals.



Why do AOD clinicians need to know how to do a baseline Mental State Examination?

“...more than one-third of individuals with an AOD use disorder have at least one comorbid mental health disorder; however, the rate is even higher among those in AOD treatment programs.”

(Mills et. al, 2009: p viii)

2 Conducting a baseline

The importance of rapport building in undertaking a baseline Mental State Examination

Taking the time to establish rapport with a client, before embarking on an MSE, is very important. Consumer feedback tells us that continuing to acknowledge the client's feelings and experiences during the information gathering process is important for the success of the interview and ongoing engagement. Clinicians need to listen closely to what the client has to say and ask for clarification or examples if needed. Showing empathy to a client's distressing thoughts and beliefs (without indicating an uncritical acceptance of the person's ideas and impulses) is appropriate.

How to do a baseline Mental State Examination

Whilst there is a comprehensive list of criteria and psychiatric terminology used in a comprehensive MSE, it is not necessary for AOD clinicians to have a detailed knowledge of all of these for a baseline MSE. What is essential is for the clinician to have an understanding of the basic concepts used in an MSE. An AOD clinician will need to be able to recognise the basic concepts in a client's presentation and then describe them in the clinician's own words. These descriptions will need to be put in a client's clinical notes.

A baseline MSE is done in the normal course of a session with a client. The clinician uses their observational and listening skills to obtain the information that they require to undertake the MSE. Open ended questions are also useful for gathering relevant information. The MSE is not a series of questions but an evaluation process based on the clinician's observations and interactions with the client.

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If mental health issues are identified during the course of an MSE, then more direct questioning about the client's experience may be required. An MSE can occur during an initial assessment or as part of an ongoing series of appointments.

They are:

1. Appearance
2. Behaviour
3. Speech and language
4. Mood and affect (feelings)
5. Thought content (thinking)
6. Perception
7. Cognition
8. Insight and judgement

Format of the baseline Mental State Examination

There are varying formats for carrying out an MSE. For the purpose of this training DVD, the format outlined in the *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*¹ will be used.

The following format can be used for recording the observations made during an MSE. Primarily there are eight domains that need to be considered and assessed.

Pages 14 to 18 provide a brief description of each of the domains listed above.

2 Conducting a baseline

Appearance

Accurately and non-judgementally describe your observations of the person's physical appearance. *How does the client look?* Consider: age, gender, race/ethnicity, build, hair style & colour, grooming, posture, level of hygiene, mode of dress, apparent level of health, signs of AOD use.

Behaviour

Accurately and non-judgementally describe your observations of the person's behaviour. Avoiding assumptions is important so signs of illness can be separated from culturally appropriate behaviours. *How does the client behave?* Consider: general behaviour, facial expression, eye contact, body movements and gestures. *How is the client reacting to being in the session?* i.e. co-operative, angry, hostile, withdrawn, inappropriate, afraid, suspicious, evasive.

Speech and language

Describe:-

- (a) How is the client talking (speech)?
- › **rate** – rapid, pressured, slow, retarded
 - › **volume** – loud, whispered, quiet
 - › **tone** – monotone, varied
 - › **quantity of information** – poverty or pressure of speech, mute/silent
 - › **quality** – stutter, slurring or any atypical qualities
- (b) How does the client express himself/herself (language [form of thought])?
- › **incoherent/illogical** – disorganised or senseless speech
 - › **derailment** – unrelated or loosely connected ideas
 - › **tangentiality or loosening of association** – unrelated or incomplete replies
 - › absence or slowing of thought
 - › **thought blocking** – thought flow is briefly interrupted or absent

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Mood and affect (feelings)

How does the client describe his/her emotional state (mood)? Exploring mood is very important because it can give an indication of potential risk to self or others. Use the client's own words if possible. Is the client down, depressed, sad, anxious, angry, irritable, happy, ok, fearful, or "up"?

What do you observe about the person's emotional state (affect)? A person's mood and affect should be congruent with each other. So when describing a person's affect, what do you observe about the client's emotional state?

For example consider the following:

- › **depressed** – is the person "flat", restricted, tearful, deflated, has blunted facial expressions?
- › **anxious** – is the person agitated, fiddly, distressed, fearful, irritable, distracted?
- › **angry** – is the person hostile, defensive, easily provoked?
- › **labile** – rapidly changing their mood.

- › **inappropriate** – expressing an inconsistent emotion to what they are talking about (i.e. laughing when talking about a loved one's death).
- › **"high" or elevated** – excessively happy or overly animated in their expressions and gestures.

Thought content (thinking)

What is the person thinking about? Consider the following:

- › **the amount of thought and its rate of production** – Does the client's speech flow easily? Does the conversation stay on track? Is there evidence of any limitation in the client's ability to think (i.e. look for slow/hesitant speech)?
- › **continuity of ideas** – Do the thoughts being expressed flow logically and stay on track? Are certain words or ideas repeated? Are there gaps in the flow of thinking?

2 Conducting a baseline

- › **disturbances of language** – Is the client's communication coherent and well organised? Are the correct words being used?
- › **delusional thoughts** – Does the client have any false beliefs that are not in keeping with cultural, religious and social norms? These delusions can present in many different ways including delusions of persecution, bizarre thoughts, grandiose ideas, self-referential thoughts, delusions of control.
- › **preoccupations** – These thoughts are very prominent in the client's mind but are not as firmly held as delusions. These include paranoid, depressive, anxious and obsessional thoughts and overvalued ideas.
- › **thoughts of harm to self or others** – Has the client expressed thoughts of harming themselves or others? This criterion also includes non-suicidal self harm such as cutting, excessive picking, burning of self. Evidence of any suicidal, self harming or homicidal thoughts need to be followed by a thorough risk assessment. This training DVD does not train clinicians on how to

conduct a risk assessment. Information on risk assessments in AOD settings is covered in the *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*, pages 46, 157, 158, 159. This document can be accessed at:

<http://www.med.unsw.edu.au/NDARCWeb.nsf/page/Comorbidity+Guidelines>

Perception

The purpose of this domain is to ascertain whether the person displays behavioural evidence of hallucinations or other perceptual disturbances.

Consider the following:

- › hallucinations are false perceptions in the absence of any stimulus. They are the most common form of perceptual disturbance, particularly auditory

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hallucinations or 'hearing voices' although they can be experienced in any of the five senses:

- › sight (visual)
- › smell (olfactory)
- › hearing (auditory)
- › touch (tactile)
- › taste (gustatory).

Hallucinations seem real to the person experiencing them. Note the degree of distress or fear associated with the particular hallucination. It is important to explore *command hallucinations*, where the voices tell the person to do a particular thing, as there may be associated risk.

- › dissociative symptoms such as:
 - › derealisation (the external world seems strange or unreal)
 - › depersonalisation (the person feels detached from their own thought processes or body).
- › illusions, where the person misinterprets sensory stimuli (e.g. hearing rustling leaves as voices).

Cognition

The purpose of this domain is to ascertain whether or not the person is alert and oriented to time and place. There is no need for AOD clinicians to undertake a complex exploration of cognition. Cognition can be observed during the course of the appointment process or explored further by asking simple direct questions.

Consider the client's:

- › **level of consciousness** – is the client alert?
- › **attention** – can the client stay focussed during the appointment?
- › **memory** – can the client tell you what he/she did yesterday/last week?
- › **orientation** – can the client tell you what day of the week it is?
- › **concentration** – can the client focus on a simple mental task, such as adding?
- › **abstract thinking** – can the client identify similarities between two related items?

2 Conducting a baseline

Insight and judgement

Insight refers to the client's capacity to recognise his/her own problems and symptoms. Judgement refers to the client's capacity to make sound, reasoned and responsible decisions.

Once the MSE is completed, a formulation can be made and an action decided upon.

Formulation and action:

Once a baseline MSE has been completed the AOD clinician can make a formulation. The formulation summarises the information gathered so the clinician can systematically develop a hypothesis about the client's mental state, which is then used to inform any action taken.

The formulation should include the nature and severity of symptoms and any risk issues. It can also include information about the client's recent and past drug use.

The counsellor can then decide whether the client:

- ▶ is appropriate for ongoing AOD counselling; or
- ▶ is appropriate for ongoing AOD counselling in conjunction with GP follow-up; or
- ▶ requires psychiatric assessment and intervention before counselling can proceed.

If unsure, the AOD clinician should consult with their supervisor or team before making the formulation and any subsequent referral. The MSE, formulation and action should be reviewed regularly to monitor any changes in the client's mental state.

Carers, family members and other supports:

If during an MSE a client is found to be significantly unwell, it is recommended that the client be asked if they would like a carer, family member or another significant other

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to be contacted for support and assistance. If it is assessed that a client's judgement is significantly impaired (and they refuse any support person to be contacted) it may be appropriate to contact the client's registered next of kin. However, this should only be carried out after consulting with a clinical supervisor.

Incorporating AOD factors in the baseline Mental State Examination

When completing an MSE with AOD clients, their current AOD use must be considered as it may affect the way the client presents.

These factors include:

- ▶ how recent was their last AOD use?
- ▶ is he/she still intoxicated?
- ▶ the presence of AOD withdrawal symptoms (depression, hallucinations, delirium tremens).

- ▶ medication being used to assist with withdrawal.
- ▶ any acquired brain injury from AOD use.

If the client is very intoxicated, or in active withdrawal, it is not appropriate to do an MSE. However, due to developed tolerance to their drug of choice, it is common for AOD clients to attend appointments whilst intoxicated and without obvious impairment to their normal level of functioning. A baseline MSE may be appropriate under these circumstances but should be discussed with a supervisor and reviewed at the earliest opportunity.

Referral process

Urgent matters (i.e. risk of harm to self or others): If a client is already known to a mental health service, the case manager or duty officer can be contacted and asked to follow up on the concerns raised. Please discuss this with your supervisor if you are not sure how to proceed.

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If the client is not known to a mental health service, and the matter is urgent, then the AOD clinician can suggest to the client the following:

- › go to the nearest emergency department (ED)
- › go to their general practitioner (GP)
- › contact the Mental Health Emergency Response Line (MHERL)

It may be appropriate, depending on the service, for the AOD clinician to contact ED or the GP and discuss their concerns prior to the client being seen, or even accompany the client when they attend for assessment.

If the client is not willing to seek help and the AOD clinician is concerned about the risk of harm to self/others then this matter should be referred to a senior manager for further assessment. The police or other emergency services may become involved if this is determined to be the appropriate action from the management of a service. As there is a duty of care in this situation confidentiality can be breached. All actions taken should be documented.

If the AOD clinician is unsure how to access appropriate mental health support they can call the duty officer at the local mental health service and discuss the referral process with them.

Less urgent matters (i.e. no immediate risk): If the client is already a client of a mental health service the case manager or duty officer can be contacted and asked to follow up on the concerns raised.

If the client has not previously sought help for mental health issues they should be referred to a GP for further assessment and treatment or referral. It may be appropriate, depending on the service, for the AOD clinician to contact the client's GP and discuss their concerns prior to the client being seen, or even accompany the client when they are assessed. It is common for AOD clients not to have a GP so assistance with making an appointment may also be required.

Some emergency and after hours contact numbers have been provided in section 5 of this booklet.



3 Visual case studies for baseline MSE training

Before continuing you should:

1. Read the previous sections of this booklet.
2. Download the *Assessment of Mental State table* from <http://www.palmerston.org.au/publications.htm>
3. Download the *Mental State Assessment form* for each case scenario you are completing (three in total if you intend to complete an assessment on all three visual case studies) from <http://www.palmerston.org.au/publications.htm>
4. **Please note:** Some versions of Windows Media Player do not support the playing of DVDs. If you are having trouble playing this DVD via your PC, its recommended you download VLC Player (www.vlc.org). If you are unable to access this website, please consult your IT administrator.

Instructions for use

Each case study has been developed to allow a clinician to practise their knowledge and skills on conducting an MSE

Press **"Start"** to watch the introduction to the DVD. This will briefly explain the purpose of the DVD and will then return to the main menu for you to select your case study scenarios. It is suggested that you complete at least two case study scenarios to practise your MSE knowledge and skills. The first case study scenario entitled *'Lisa without commentary'* and *'Lisa with commentary'* is suggested for all clinicians.

In all cases, the case study scenario *"without commentary"* should be played first. Once you have finished watching the *"without commentary"* case study scenario, return to the main menu of the DVD. Then using the table and MSE form (that you have downloaded from the internet) attempt to complete an MSE on the client presented. Once you have finished, watch the *"with commentary"* case study scenario in its entirety. The scenario *"with commentary"* should only be played after you have watched

the *"without commentary"* case study, as this will replay the same case study but will also contain some additional comments on how to carry out an MSE on that client.

If necessary, you can take notes while watching the case study scenarios. Remember, there is no "right" or "wrong" way of writing your assessment and observations of a client. Try to use simple language that is non-judgemental and follow the MSE guidelines in the *Assessment of Mental State table* to the best of your ability.

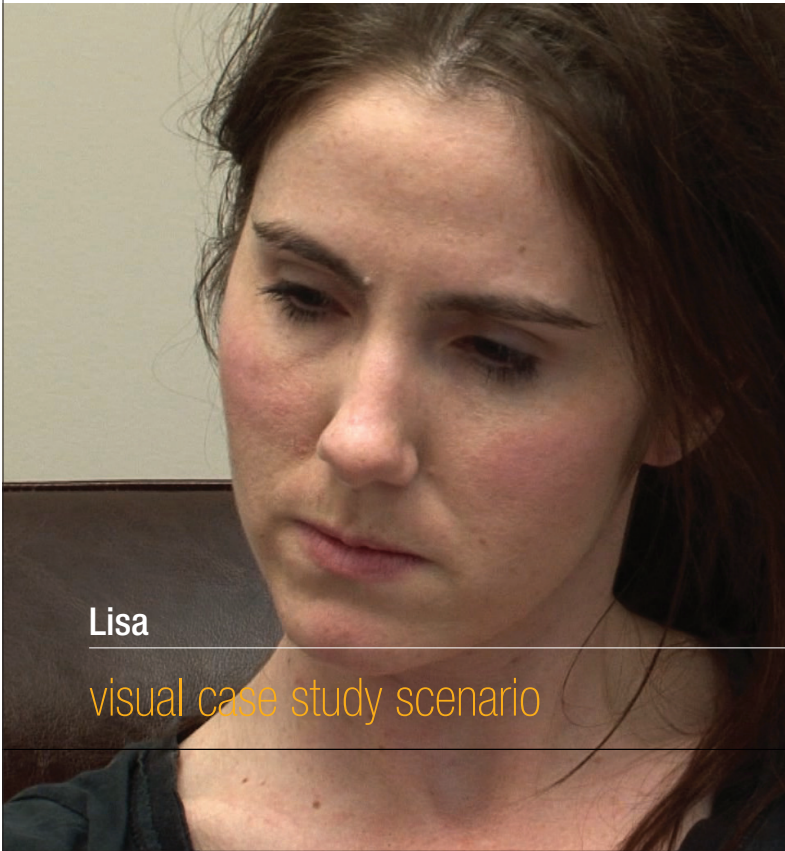
To view an example of an MSE on each client (on Lisa, Glen and Barry) please go to section 4 of this booklet. It may be useful to read these examples *after* you have finished completing your MSE on each case study scenario, and while you are watching the *"with commentary"* version of the case study scenario.

The following pages provide an example of an MSE assessment on each visual case study scenario. Please note that these responses are to be used as a guide only and may differ according to clinical judgement.

4 Example of an MSE assessment on each visual case study scenario



4 Lisa: MSE Assessment Example



Lisa

visual case study scenario

Example

Appearance:

Lisa is a 26 year old Caucasian woman, of slim build with long dark hair. She was dressed in crumpled jeans, which appeared dirty, and a T-shirt. She appeared to be in good health overall but with a poor level of personal care and grooming (which is unusual for Lisa who is known to the service).

Mood and affect (feelings):

Lisa's mood was not depressed or elevated but she appeared anxious, fearful and agitated.

Thought content (thinking):

Lisa's speech flowed easily and she expressed herself clearly. She sometimes paused mid-sentence, appearing to be distracted by unseen stimuli, and at times had to be refocused on the conversation.

Behaviour:

Lisa was agitated and restless, moving in her chair and playing with her hair during the appointment. Her eye contact was intermittent. She was distracted in the session and at times she seemed to be responding to unseen stimuli (voices). Despite appearing to be unwell she communicated freely and was co-operative.

Lisa showed signs of paranoid and delusional thinking. She believed people were spying on her with cameras and microphones in her home. This is why she slept in the garden shed. She also thought her boyfriend had inserted a transmitter into her stomach while she was asleep. To her, this meant that her thoughts were being monitored.

Speech and language:

Lisa's speech was of normal tone and rate.

4 Lisa: continued...

Thoughts of harm to self or others (risk assessment): Lisa holds the belief that her boyfriend wants to harm her, so she is protecting herself by sleeping in the garden shed with a knife under her pillow. There is no history of domestic violence in the relationship nor does Lisa's boyfriend have a history of harming others. While Lisa holds the belief that her boyfriend wants to harm her, there may be a risk of harm to him. Lisa has no previous history of self harm or harm to others.

Perception:

Lisa was experiencing auditory hallucinations. She reported she was hearing different voices saying "horrible" things such as "you are no good", "you are ugly" and that she needs to protect herself from her boyfriend. She was observed replying to what appeared to be voices during the appointment.

Cognition:

Lisa had misplaced her medications and could not remember when she had last taken her tablets. She usually relies on her parents giving

her the medication. Lisa also found it difficult to concentrate during the session. Otherwise she was alert and oriented to time and place.

Insight and judgement:

Lisa showed insight and judgement. She was willing to consider that the experiences she was having could be due to a recurrence of her mental illness and was agreeable to the Mental Health Service being contacted for further assessment.

Formulation:

Lisa's mood and affect are congruent. She said she felt worried and she presented as fearful. Her speech was normal in rate and tone. She showed signs of delusional and paranoid thinking, believing she was being spied upon by cameras in the house and that her boyfriend had planted a transmitter in her stomach so everyone would know what she was thinking. She said she was hearing derogatory voices and was seen to be actively listening and replying to them during the appointment. The voices are also

commanding, telling her she needs to protect herself from her boyfriend. Lisa is sleeping with a kitchen knife under her pillow in case he comes into the garden shed during the night. Her boyfriend may be at risk of harm in this situation. Although Lisa was convinced as to the reality of what she was experiencing, she showed some insight into her own mental health and was agreeable to being assessed at the local Mental Health Service.

Lisa has a diagnosed mental illness and has not been taking her medication for some weeks. She is a regular cannabis smoker and has used speed twice in the last week.

Action:

The duty officer at the Mental Health Service was notified of the AOD counsellor's concerns about Lisa's mental health and possible risk to her boyfriend. An afternoon appointment was arranged for Lisa with her mental health worker. Although Lisa stated she was capable of attending the appointment by herself, it may also be appropriate for the AOD counsellor to ask Lisa if she would like a carer or family member to be contacted to help her attend

the appointment. Lisa can continue to attend AOD counselling as well as addressing her mental health issues with a mental health specialist.

4 Glen: MSE Assessment Example



Glen

visual case study scenario

Example

Appearance:

Glen was casually but neatly dressed.

Behaviour:

Glen was agitated and was seen pacing in the waiting room. He looked down for most of the interview and was fidgeting with his hands.

Speech and language:

Glen's speech was quiet but of normal rate. Although he was upset he expressed himself clearly.

Mood and affect (feelings):

Glen says he is angry and he appears flat and depressed.

Thought content (thinking):

Glen's conversation was dominated by his anger and distress over the loss of his father but there was no evidence of delusional thinking, or preoccupation beyond what is normal for a person experiencing grief.

Thoughts of harm to self or others (risk assessment): Glen acknowledges that he is angry and upset but also says he has no intention of harming himself, or anyone else as there is no one person or agency to blame. He is future focussed, wanting to keep his job and relationship intact. No suicidal risk or risk of harm to others was ascertained.

Perception:

There is no evidence of hallucinations or perceptual disturbances.

4 Glen: continued...

Cognition:

Glen is alert and orientated to time and place.

Insight and judgement:

Glen's insight and judgement are intact. He was able to make the link between his increased alcohol intake, stress and problems in his relationship, as well as his anger and grief over his father's death. He had taken leave from work to attend counselling as he was aware he was not coping.

Formulation:

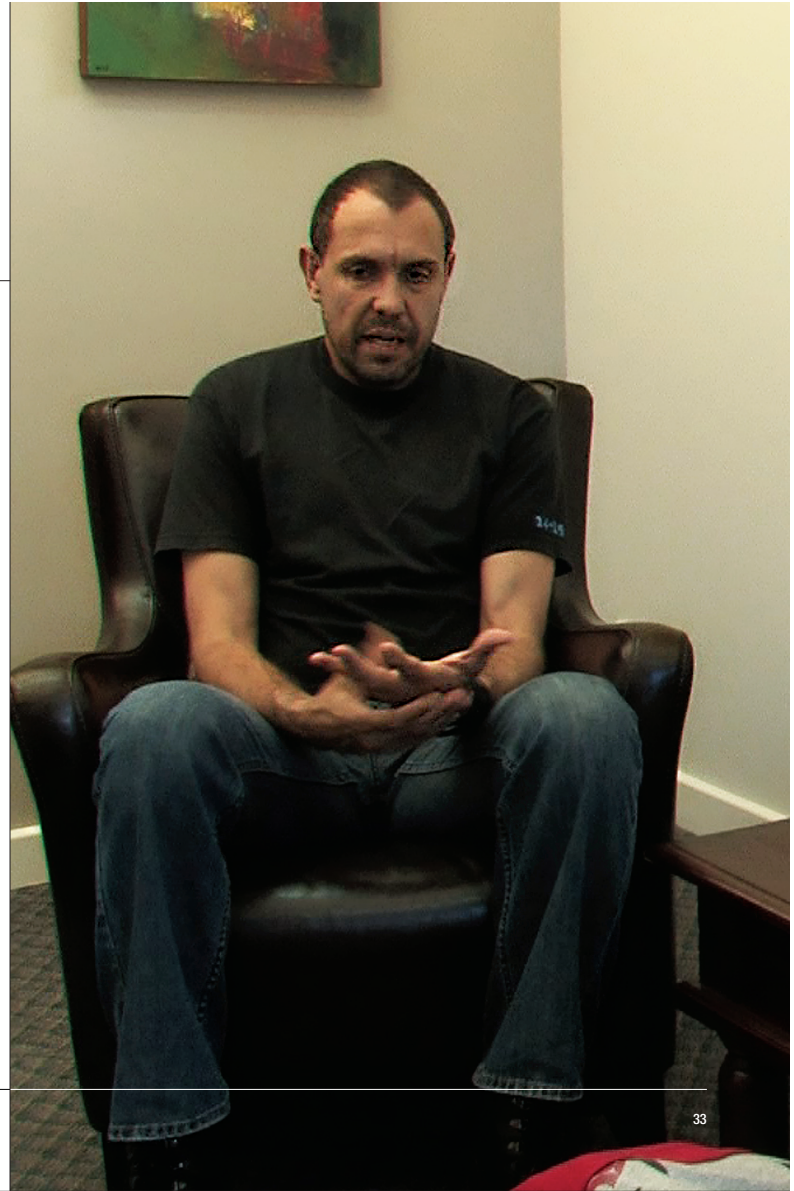
Glen was initially angry and upset in the interview and he described himself as 'stressed'. His father had recently died in tragic circumstances and he was experiencing relationship problems. He communicated easily and coherently and showed no evidence of delusional thinking. Glen expressed his emotions and indicated no intent to harm himself or anyone else. He showed insight and judgement in that he recognised he was

not coping well and had taken leave from his employment to get some help.

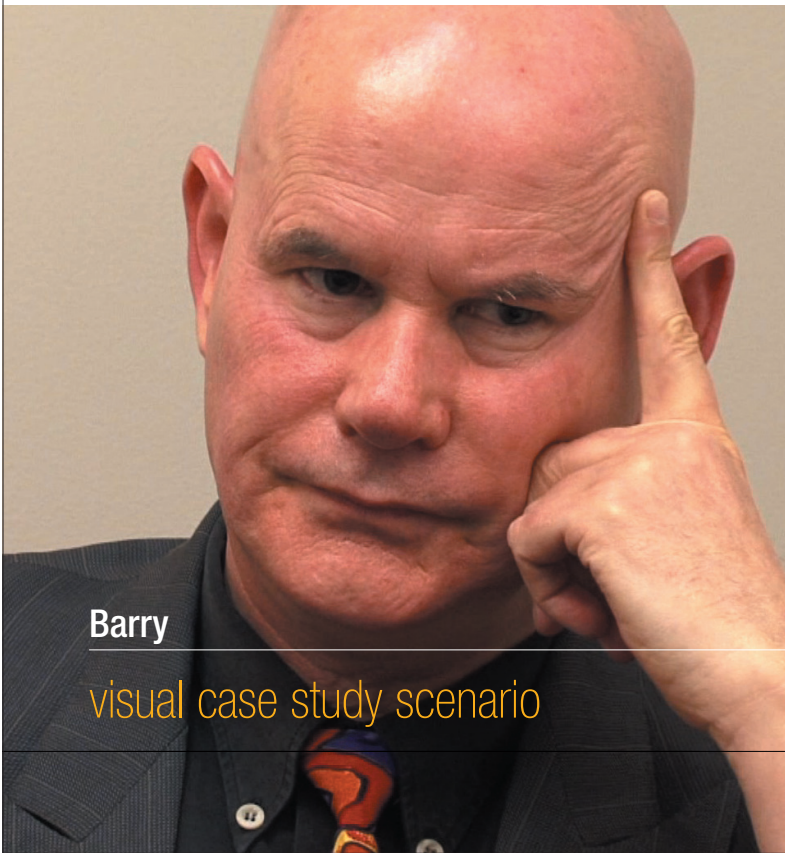
Glen says his alcohol intake has increased to six cans on a week night and increases significantly when he goes out drinking with his mates.

Action:

Glen is suitable for ongoing counselling at the AOD service without further referral to a mental health service or GP at this stage.



4 Barry: MSE Assessment Example



Barry

visual case study scenario

Appearance:

Barry is well dressed in a suit and tie. His face appears flushed and stressed.

Behaviour:

Barry seems hostile, frustrated and uncomfortable and uses a lot of hand gestures that include rubbing his forehead and eyes.

Speech and language:

Barry spoke with a clear tone occasionally raising his voice. Although stressed he expressed himself clearly.

Mood and affect (feelings):

Mood: Barry described himself as feeling betrayed (by his wife) and "just getting through". He also said he was not sleeping well and was waking during the night "in a panic".

Affect: Barry was initially irritable but overall his mood appeared to be quite low. He became tearful when he spoke of his brother's suicide two years ago. His presentation matched his description of how he felt.

Thought content (thinking):

Barry is stressed and anxious and thinks his wife and boss are colluding against him.

Thoughts of harm to self or others (risk assessment): Although Barry has thought about suicide he feels he would never do that to his children as he saw what his brother's children went through. Barry admits he would benefit from further counselling.

Perception:

There is no evidence of hallucinations or perceptual disturbances.

4 Barry: continued...

Cognition:

Barry is alert and oriented to time and place.

Insight and judgement:

Barry justified his drinking as part of his work with clients and felt his boss and ex-wife were in collusion with each other. Barry did show some insight and judgement acknowledging he needed further counselling as he was not coping with his marriage break-up and his brother's suicide two years ago.

Formulation:

Barry is not sleeping well. He is waking during the night "in a panic" and he is still grieving the suicide of his brother two years ago. Barry is upset and angry that his wife has recently left him. His irritability and alcohol use have increased to the point where it has become a problem at work and he has been sent for counselling. Barry does not show any signs of confused, disordered or delusional thinking. He shows judgement in that he sees the need

to address his behaviour so he does not lose his job. Initially he is a reluctant attendee and is inclined to blame his ex-wife and boss for the situation he finds himself in. However, he engages well with the counsellor and begins to make the links between his grief over his brother's death, his increased alcohol use and subsequent marital and employment problems. Barry denies any suicidal intent citing his children as a protective factor.

Barry is drinking two bottles of wine a night and regularly takes Nurofen Plus as a sleeping aid.

Action:

Barry is suitable for ongoing counselling at the AOD service but a GP appointment to discuss his low mood, poor sleep, feelings of panic and use of Nurofen Plus should be encouraged. He was also given a leaflet with emergency counselling contacts in case his mood worsened between appointments. The counsellor should discuss this session with a supervisor and monitor Barry's mood and risk of suicide at subsequent appointments.



5 Emergency and after hours contacts

Clients who have to wait for a medical or psychiatric appointment can be given the after hours emergency contact numbers for confidential mental health emergency support services and help lines. Some of these services are listed below:

MENTAL HEALTH EMERGENCY RESPONSE LINE (MHERL)

Metro callers phone 1300 555 788 or (08) 9224 8888

Rural and remote area callers Freecall (including Peel) 1800 676 822

RURAL LINK

Rural and remote area callers Freecall 1800 552 002

LIFELINE

13 11 14

KIDS HELP LINE

Counselling and support provided for young people (to 24 years old) who are feeling depressed, sad, or lonely – or just need someone to talk to.

Phone 1800 55 1800

THE SAMARITANS

Careline phone (08) 9381 5555

Country callers Freecall 1800 198 313

Youthline phone (08) 9388 2500

6 References

¹Mills K L, Deady M, Proudfoot H, Sannibale C, Teesson M, Mattick R, Burns L. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. National Drug & Alcohol Research Centre, University of NSW. Australian Government, Department of Health & Ageing; 2009.

The intention of this Mental State Examination (MSE) DVD and accompanying booklet is to assist alcohol and other drug (AOD) clinicians to be more confident in completing a baseline MSE on their clients.

The DVD has been designed to be an instructional training tool and is best used in conjunction with first reading the accompanying booklet. The DVD has three visual case scenarios which clinicians can use to test their knowledge and skills in conducting an MSE.

Please note: Some versions of Windows Media Player do not support the playing of DVDs. If you are having trouble playing this DVD via your PC, its recommended you download VLC Player (www.vlc.org). If you are unable to access this website, please consult your IT administrator.

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hepatitiswa



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