THE MENTAL STATE EXAMINATION

A clinician assesses aspects of a person's mental state across the assessment process, from the initial observation of the person and while taking their history. A detailed Mental State Examination encompasses the full range of a person's expression and not just what they say. The clinician will observe a person's apparent mood, how they behave in the session, note details of their speech and how the person is responding during the interview, and in turn how the clinician is responding to the person. A thorough assessment of mental state will cover the following areas (NB Many of these overlap but have been described separately for clarity).

Appearance and general behaviour: This includes the person's facial expressions, body language, posture, gestures, manner, attire and grooming. These may give clues to the person's personality, mood, awareness of social conventions and ability to take care of themselves. A psychotic person may behave very bizarrely, or a depressed person may appear unkempt or dishevelled.

Attitude towards the interviewer: This includes whether the person was suspicious or hostile, evasive, tentative, or co-operative and whether the interviewer felt some rapport had been established. It is also important for the interviewer to consider their reaction to the person. The degree of rapport or therapeutic engagement established is directly related to how willing a person will be to disclose painful or difficult material. This is crucial in assessing for suicide risk as a disengaged or obviously reluctant person may not give a full account of their risk or intent if they do not trust the interviewer or want to be taking part in the assessment process. In such circumstances, it is particularly important to give weight to information from others and to balance this against any denials of suicidal intent during the interview that appear contradictory to these reports.

Affect/mood: Affect refers to the prevailing emotional tone of the interview, and is assessed through the person's facial expression, body posture, and tone of voice. Mood is more of a prolonged feature that is reported by the person (and others if available). A clinician should look for how emotionally responsive a person is during an interview, whether they appear flat and apathetic or at the other extreme, labile or irritable. It is also important to consider whether their reported mood matches their displayed mood (eg, someone who is speaking slowly, wringing their hands and is intermittently tearful but says they are 'fine' needs to be assessed further). Important dimensions of mood to assess for include depressed mood (eg, sad, tired etc), elated or euphoric mood, irritability and agitation. A clinician should also be aware of obvious signs of tension (eg, sweating, stammering, trembling) and reported anxiety.

Psychomotor activity: This refers to internally driven behaviours, for example, drumming of fingers that may represent feelings of anxiety. Typical behaviours that the clinician should be aware of include restlessness/agitation; slowing of movement, speech and thoughts; questions answered after prolonged delays.

Speech: A great deal of additional information can be gained from listening to how a person speaks and not just the content of their speech. The clinician should listen for the loudness and speed of speech and how effective the person is in getting their point across. For example, a person who has pressured speech may feel compelled to talk and the listener may gain the impression that their ideas flow faster than they can express them. A depressed person may demonstrate 'poverty of speech', such as responding after delays with 'I don't know', or very short or monosyllabic replies.

Thought content: Inferences about a person's thinking are made on the basis of their report of symptoms. A careful exploration of a person's presenting difficulties and history is crucial if the clinician is to gain an accurate picture of their thinking. In assessing for suicidality a clinician will pay particular attention to suicidal ideation and depressive thoughts (eg, 'I'm no good, I'd be better off dead'). The clinician should ask the person about their beliefs about themselves, others and their place in the world, and screen for the presence of delusional beliefs, anxious thinking, obsessions etc.

Thought process: Again, the clinician makes inferences about a person's thinking based upon their speech. When assessing thought processes the clinician is looking for evidence of the way the person constructs their thoughts, including sequence and speed. Marked difficulties in thought processes may include perseveration (ie, when a person seems to be stuck on one theme), tangentiality (ie, easily side-tracked without being able to return to the initial topic), or loose associations (ie, apparent absence of logical thought processes). A clinician will also be looking at the person's style of thinking (eg, do they worry or ruminate over their misfortunes, are they preoccupied with certain topics/events/ideas? For example, a person may report negative self-talk as above, but then also report that one thought triggers another related one, and another, until they feel like they can't 'shut them off').

Perceptual disturbance: In this instance the clinician is specifically screening for the presence of hallucinations. These may occur across any of the five senses. If the person is suicidal and hearing voices, care must be taken to assess whether these voices are command hallucinations (ie, telling the person to act) and how compelling these commands are. It is also important to assess for the degree of fear associated with the experience of hallucinations as this may also increase a person's suicide risk (ie, ending one's life to escape the feared hallucination).

Orientation: Briefly, this is a screen to check that the person knows where they are, who they are and why they are being interviewed. This series of questions is especially important if the person has come into the emergency department (eg, following an overdose). If the person is disoriented to place, person or time, careful examination is needed to rule out delirium, intoxication or organic complications. Disorientation in time, especially the passage of time (such as the length of the interview), is the most sensitive of these tests of orientation.

Insight and judgment: A clinician needs to judge how much the person is aware of their present circumstances, their health and the reasons for their presentation to mental health services or an emergency department. If a person is assessed as being significantly impaired in their judgment, in a way that places them at risk of harm to themselves or others, they can be compelled to have treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Intelligence/cognitive function: For the purpose of a suicide assessment a broad estimation of a person's intellectual functioning is sufficient. This can be inferred from the content of their speech, educational history and vocational background. Other aspects of cognitive functioning to screen for are attention and concentration and any memory problems. The clinician can be aided in this by using the Mini Mental State Examination.[86]