SUD Technical Assistance Webinar Series

VIRGINIA MEDICAID: 31—
MENTAL STATUS EXAM
PAUL BRASLER, LCSW
NOVEMBER 4 & 9, 2021

Department of Medical Assistance Services
Welcome and Meeting Information

• WebEx participants are muted
  ▪ Please use Q&A feature for questions
  ▪ Please use chat feature for technical issues

• Focus of today’s presentation is practice-based – please Contact SUD@dmas.virginia.gov with technical or billing questions

• We are unable to offer CEUs for this webinar series
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The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,997,093 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.
Naloxone Resources

► Get trained now on naloxone distribution
  ▪ REVIVE! Online training provided by DBHDS every Wednesday
  ▪ [https://getnaloxonенow.org/](https://getnaloxonенow.org/)
    ▪ Register and enter your zip code to access free online training

► Medicaid provides naloxone to members at no cost and without prior authorization!

► Call your pharmacy before you go to pick it up!

► Getting naloxone via mail
  ▪ Contact the Chris Atwood Foundation
  ▪ [https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422](https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422)
    ▪ Available only to Virginia residents, intramuscular administration
SUPPORT Act Grant Website -
https://www.dmas.virginia.gov/#/artssupport
The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.

We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.

The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.
Fall 2021 Webinars

► Mental Status Exam: 11 – 4, 1 – 2 PM & 11 – 9, 10 – 11 AM
► Urine Drug Screens: Purpose & Practice: 11 – 16, 10 – 11 AM & 11 – 18, 1 – 2 PM
► Behavioral Addictions: Gambling, Gaming & More: 11 – 23, 10 – 11 AM & 11 – 30, 1 – 2 PM
► Stigma in SUD & SUD Treatment: 12 – 7, 10 – 11 AM
► Contingency Management: 12 – 14, 10 – 11 AM & 12 – 16, 1 – 2 PM
Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.
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First Things First…

- Even the best assessment policy, process, tools or forms cannot replace an empathetic, trained provider
- Prior to even thinking about doing an assessment, we need to agree:
  - People are worthy of help, have the right to self-determination, and should be treated with respect and dignity
  - Our role is to walk with our clients; not live their lives for them, and to respect their choices, even when those choices are things we disagree about
  - No one sets out to become addicted to substances or behaviors
  - Recovery is possible and is defined by the client
Language

- We want to use “Person-Centered language”
  - Not “Addict,” but Person who uses drugs or Person with a substance use/behavioral disorder
  - Not “Addiction,” but Substance Use Disorder (SUD)
  - Not “Abuse,” but Use
  - Not “Clean,” but In Recovery or Testing Negative
  - Not “Dirty,” but Testing Positive
  - Not “Relapse,” but Return to Use

- At the same time, out of habit, I may inadvertently use some of these older words/terminology—and some of the sources I quote use older terms

- Be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc., or may refer to “clean time” as how long they have been in recovery (and we need to respect this)
Assessment Overview

► All clients should receive a comprehensive behavioral health assessment as part of the treatment process, regardless of the service setting.

► Assessing clients includes **four primary areas** (plus an additional two areas if time permits) of focus:

A. **Suicide/Lethality Assessment**
B. **Substance Use Assessment**
C. **Mental Status Exam**
D. **Basic Trauma Assessment**
E. **Medical & Mental Health History**
F. **Family & Social History**
Mental Status Exam
Examines the following

- Appearance
- Attitude
  - Rapport
- Behaviors
- Mood
- Affect
  - Range of expression
- Speech
  - Volume
  - Rate
- Thought process
- Thought content
  - Delusions
  - Hallucinations
  - Obsessions
- Cognition
  - Orientation
  - Memory
- Reliability
- Insight
- Judgement
Mental Status Exam: Appearance

- **Age**
  - Does the client appear his/her stated age?
- **Height & weight**
  - Does the client appear to be malnourished?
- **Sex** (include gender expression and gender identification if different from biological sex)
- **Ethnicity** an/or cultural identity
- **Overall level of hygiene and presentation**
  - Is the client malodorous?
- **Manner of dress**
  - Congruent with the season/weather?
- Any signs of **injury**?
MSE: Rapport

- **Rapport**: The client’s approach to the interview process and clinician
- The most subjective element of the mental status examination; **attitude**, depends on the interview situation, the skill and behavior of the clinician, and any pre-existing interactions between the clinician and the patient.
- The patient's attitude may be described as **cooperative, uncooperative, hostile, guarded, suspicious** or **regressed**
- Attitude is important for the clinician's evaluation of the **quality of information obtained** during the assessment.
**MSE: Behavior**

- **Stereotypies**: Repetitive purposeless movements such as rocking or head banging
- **Mannerisms**: Repetitive quasi-purposeful abnormal movements such as a gesture or abnormal gait may be a feature of chronic schizophrenia or autism
- **Eye contact**: Quality of eye contact can provide clues to the client’s emotional state
  - Repeatedly glancing to one side can suggest that the patient is experiencing hallucinations
  - Lack of eye contact may suggest depression, schizophrenia or autism spectrum disorder
MSE: Behavior

- Abnormalities of behavior, also called abnormalities of activity, include observations of specific abnormal movements, as well as more general observations of the patient’s level of activity and arousal. This can include:
  - Gait
  - Tremors
  - Tics
- Any evidence of Catatonia:
  - Echopraxia: Involuntary imitation of other person’s movements or actions
  - Catalepsy: A medical condition characterized by a trance or seizure with a loss of sensation and consciousness accompanied by rigidity of the body
  - Waxy flexibility
More **global behavioral abnormalities** may be noted, such as an increase in arousal and movement (described as *Psychomotor agitation* or *Hyperactivity*) which might reflect mania or delirium.

An inability to sit still might represent **Akathisia**: A feeling of inner restlessness and a need to constantly move, a side effect of antipsychotic medication.

Similarly a global decrease in arousal and movement (described as *psychomotor retardation, akinesia* [muscle rigidity] or *stupor* [person is entirely unresponsive]) might indicate depression or a medical condition such as Parkinson's disease, dementia or delirium.
MSE: Mood

- A **subjective** state based on how the client says that they feel and observations from the clinician.
- **Mood** is often described using the patient's own words, but can also be described in summary terms such as *euthymic, depressed, sad, euphoric, angry, anxious* or *apathetic*.
- **Alexithymic** individuals may be unable to describe their subjective mood state.
- An individual who is unable to experience any pleasure may be suffering from *Anhedonia*.
MSE: Mood Continuum

**Hyperthymia:** An extremely happy mood

**Euthymia:** Reasonably positive mood

**Dysthymia:** Depressed mood
MSE: Affect

- **Objective** when compared to the subjective description of mood
- **Largely based on clinical observations of the client**
- Some of the same words are used (e.g., sad, depressed, euthymic, etc.), but the following **parameters** are also used:
  - **Congruent** or **incongruent** with their thought content (e.g., someone shows a bland affect or is nonchalant when discussing a recent traumatic event)
  - **Mobility/lability**: The extent to which affect changes during the interview: the affect may be described as **labile**, **constricted**, or **fixed**
MSE: Affect Range of Expression

- **Expansive affect**: Exaggerated emotions, often seen in the presence of a manic or hypomaniac episode
- **Euthymic**: Stable, WNL affect
- **Constricted**: The patient demonstrates a euthymic range of emotions, but the emotions are not strong; often seen in people with depression or posttraumatic stress disorder
- **Blunted**: A very limited range of emotions; seen with a variety of mood disorders, trauma disorders and psychotic disorders
- **Flat**: Little to no expression of emotions; mainly seen in people with severe Major Depressive Disorder with or without psychotic features and schizophrenia
MSE: Speech

- **Production:** Spontaneous speech as “typical” speech
- **Volume**
- **Rate:** Overly rapid or slow speech can indicate problems
- **Specific features:**
  - *Pressured speech* is common in people who are in a manic state
  - *Echolalia* (repetition of another person's words) AND
  - *Palladia* (repetition of the subject's own words) can be heard with patients with autism, schizophrenia or Alzheimer's disease
MSE: Speech Continuum

- Hypoverbal
- Spontaneous Speech—Within Normal Limits
- Hypoverbal
- Pressured Speech
MSE: Thought Process

- Thought process cannot be directly observed, and can only be described by the patient, or inferred from a patient's speech.
- The disorganization of normal thought processes is broadly referred to as **formal thought disorder**.
- Formal thought disorder is a common feature of psychosis.
- These abnormalities in formal thought processes can be thought of as falling on a "linear" continuum from goal directed to severely compromised.

Goal Directed  ▶  Circumstantial  ▶  Tangential  ▶  Looseness of Associations  ▶  Word Salad
MSE: Thought Process

- **Circumstantial:** Loss of capacity for goal-directed thinking; the client brings in many details, but usually gets back to the main point.

- **Tangential:** The client pursues thoughts stimulated by various external or internal stimuli, usually with understandable associations, but never returns to the original point.

- **Loose Associations:** Shifting of ideas from one to another with little to no logical connection; sometimes called derailment.

- **Word Salad:** Language is nonsensical.

- **Blocking:** Speech and train of thought is interrupted and picked up again in a few moments.

- **Perseveration:** Needless repetition of the same thought or phrase in response to a prior stimuli.
MSE: Thought Content

- The main theme of the client’s focus
- Includes:
  - Obsessions and Preoccupations
  - Delusions
  - Hallucinations
  - Illusions
  - Suicidal ideation
  - Homicidal ideation
  - Depersonalization/Derealization
MSE: Thought Disorder Continuum

Preoccupations  Obsessions  Delusions
Thoughts which are not fixed, false or intrusive, but have an undue prominence in the person's mind.

Clinically significant preoccupations include thoughts of suicide, homicide, suspicious or fearful beliefs associated with certain personality disorders, depressive beliefs (for example that one is unloved or a failure), phobias, or the cognitive distortions of anxiety and depression.
MSE: Thought Content—Obsessions

- **Obsessions**: An *Overvalued idea*; a false belief that is held with conviction but not with delusional intensity.

- An **Obsession** is an "undesired, unpleasant, intrusive thought that cannot be suppressed through the patient's volition" (Dr. Bruce Stevens).

- Obsessions are typically intrusive thoughts of violence, injury, sex, obsessional doubt, or obsessive ruminations on intellectual themes (i.e., religion).

- **Hypochondriasis**: An obsession that one is suffering from an illness.

- **Dysmorphophobia**: An overvalued idea that a part of one's body is abnormal, and people with anorexia nervosa may have an overvalued idea of being overweight.
A Delusion is "a false, unshakeable idea or belief which is out of keeping with the patient's educational, cultural and social background ... held with extraordinary conviction and subjective certainty" (Dr. B. Stevens)

The patient's delusions may be described as: Persecutory or paranoid, delusions of reference, grandiose, erotomanic, control, bizarre, jealousy, or misidentification of others

Delusions may be described as mood-congruent (the delusional content is in keeping with the mood), typical of manic or depressive psychoses, or mood-incongruent (the delusional content is not in keeping with the mood) which are more typical of schizophrenia
MSE: Thought Content—Perceptions

- Any sensory experience, and the three broad types of perceptual disturbance are:
  - Illusions
  - Pseudo-hallucinations
  - Hallucinations

- An Illusion is defined as a false sensory perception in the presence of an external stimulus; in other words a distortion of a sensory experience, and may be recognized as such by the subject.
MSE: Thought Content—Perceptions

- A **Pseudo-hallucination** is experienced in internal or subjective space (for example as "voices in my head")

- **Auditory pseudo-hallucinations** are suggestive of dissociative disorders (e.g., Posttraumatic Stress Disorder and occasionally Borderline Personality Disorder)

- Many of the visual effects of hallucinogenic drugs are more correctly described as visual illusions or visual pseudo-hallucinations, as they are distortions of sensory experiences, and are not experienced as existing in objective reality
A **Hallucination** is defined as a false sensory perception in the absence of any true external stimulus (i.e. experienced by the client as real).

Hallucinations can occur in any of the five senses, although **Auditory** and **Visual** hallucinations are encountered more frequently than **Tactile** (touch), **Olfactory** (smell) or **Gustatory** (taste) hallucinations.

Any type of hallucination other than auditory is suspicious of organic conditions such as neurologic disorders, delirium, and drug intoxication or drug withdrawal syndromes, as well as malingering.
MSE: Thought Content—Perceptions

- **Third-person hallucinations**: Voices talking about the patient and hearing one's thoughts spoken aloud, and

- **Second-person hallucinations**: Voices talking to the patient, threatening, insulting or telling the client to commit suicide, may be a feature of depression with psychosis or schizophrenia

- I always ask the client to point to where the voices are coming from in the room. If they point to their own heads, I become suspicious that the person’s claims of hallucinating are valid—but I do take any statements of self-harm or harm to others seriously
MSE: Thought Content—Perceptions

Other sensory abnormalities include:

- **Déjà vu**: A distortion of the patient's sense of time
- **Depersonalization**: A distortion of the sense of self
- **Derealization**: A distortion of a sense of reality
MSE: Cognition

- **Alertness**: A global observation of **level of consciousness** (i.e. awareness of, and responsiveness to the environment; this might be described as alert, clouded, drowsy, or stuporous)

- **Orientation**: Assessed by asking the patient where he or she is (for example what building, town or state) and what time it is (time, day of the week, date), their name and the context or purpose for which they are meeting with you

- **Attention**: Measures the patient’s ability to focus on the task at hand

- **Concentration**: Measures the client’s ability to sustain focus over time (e.g., Serial Sevens test)
MSE: Cognition—Memory & Language

- **Memory** is assessed in terms of:
  - **Immediate registration**: Repeating a set of words
  - **Short-term memory**: Recalling the set of words after an interval, or recalling a short paragraph
  - **Long-term memory**: Recollection of well-known historical facts

- **Language**: Assessed through the ability to name objects, repeat phrases, and by observing the individual's spontaneous speech and response to instructions
MSE: Reliability & Insight

- **Reliability**: Accuracy, truthfulness, ability to give a consistent history

- **Insight**: The person’s understanding of his or her mental illness is evaluated by exploring his or her explanatory account of the problem, and understanding of the treatment options

- In this context, insight can be said to have three components: **Recognition** that one has a mental illness, **Compliance** with & motivation for treatment, and the **Ability** to re-label unusual mental events (such as delusions and hallucinations) as pathological

- Impaired insight is characteristic of psychosis and dementia, and is an important consideration in treatment planning and in assessing the capacity to consent to treatment
MSE: Judgment

- Refers to the client's capacity to make sound, reasoned and responsible decisions.
- Contemporary practice is to inquire about how the patient has responded or would respond to real-life challenges and contingencies.
- Assessment would take into account the individual's executive system capacity in terms of impulsiveness, social cognition, self-awareness and planning ability.
- If a person's judgment is impaired due to mental illness, there might be implications for the person's safety or the safety of others.
Additional Information

The following additional items are not technically part of the mental status exam, but should also be asked as part of a comprehensive assessment as they impact the client’s mental status:

A. Mental health history
B. Quality of sleep
C. Appetite
Mental Health Symptoms:
- Duration
- Intensity

Treatment:
- Type
- Duration
- Effectiveness

Medications:
- Side-effects

Family history of mental illness, including suicides, suicide attempts and psychiatric hospitalizations
Appetite & Sleep

Appetite:
- A decrease in appetite is a common symptom of depression
- “When is the last time you had something to eat?”
- “Have there been any changes to your appetite recently?”

Sleep:
- Sleep problems often precipitate many psychiatric problems and insomnia, or hypersomnia, are also common symptoms for a variety of mental health problems
- “Have there been any changes to your sleep recently?”
MSE: Cultural Considerations

- There are potential problems when the MSE is applied in a cross-cultural context when the clinician and patient are from different cultural backgrounds.
- For example, the patient's culture might have different norms for appearance, behavior and display of emotions.
- Culturally normative **spiritual and religious beliefs** need to be distinguished from delusions and hallucinations—these may seem similar to one who does not understand that they have different roots.
- Cognitive assessment must also take the patient's language and educational background into account.
- The clinician's racial bias (conscious and unconscious) is another potential issue to address.
References


