



REVIEW ARTICLE

Nurses' experiences when conducting the mental state examination (MSE): A scoping review

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Abstract

The Mental State Examination (MSE) is an assessment framework used to facilitate the collection of subjective and objective data about a person's current mental state. There is a lack of understanding of nurses' experiences when conducting the MSE. The aim of this scoping review is to identify, examine and summarize the available literature relating to nurses' experiences when conducting the MSE. A scoping review was conducted using Arksey and O'Malley (2005) framework to review, examine and synthesize the available literature on nurses' experiences with the MSE. A PRISMA flow diagram was used to describe the systematic literature search. Six databases (APA PsycInfo, CINAHL, MEDLINE, PubMed, ProQuest, and Scopus) were searched including reference lists of eligible sources. Google Scholar, Trove and Proquest Dissertation and Thesis were searched for grey literature. Twelve articles included in this scoping review considered nurses' experiences when conducting the MSE. The principles of thematic analysis were used to synthesize the studies. Three distinct themes were identified from the literature: (i) Nurses' role and the MSE, (ii) Nurses' competence and knowledge when conducting the MSE, and (iii) Nurses' confidence when conducting the MSE. The results of this scoping review identified the MSE as a component of the mental health nursing role and a core competency of mental health telephone triage services. The MSE was used by nurses in the Emergency department (ED), acute in-patient and community mental health settings, including mental health telephone triage services. Nurses working in EDs and acute in-patient mental health settings experienced a lack of confidence and competence, including a knowledge deficit in conducting the MSE in comparison to nurses working in community mental health settings. Community mental health nurses identified the importance of conducting an MSE higher than acute in-patient mental health nurses. This review identified the need for evidence-based research related to the MSE and its application in nursing practice. Evidence-based research will inform the development of MSE guidelines and policies, thus, enhance mental health nursing practice related to the MSE, including improving and strengthening consumer-nurse therapeutic alliance in acute in-patient mental health settings.

KEYWORDS

mental health nurses, mental state assessment, mental state examination, MSE, nursing

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INTRODUCTION

Mental health is a global issue with one in every eight people or 970 million people in the world living with a mental illness (WHO, 2022). A comprehensive mental health assessment inclusive of a Mental State Examination (MSE) is conducted upon engagement with mental health services (Wand et al., 2019). Nurses are at the forefront of conducting the MSE (Johnston & Cowman, 2008). The MSE has evolved over time from different regions across the world (Neto et al., 2019). Although largely influenced by Karl Jasper's philosophically oriented concepts on psychopathology (Telles-Correia et al., 2018), the application of the term MSE has been attributed to Adolf Meyer, a Swiss-American psychiatrist (Engel, 1979). Proficiency in conducting MSEs has become an essential nursing skill taught in the undergraduate nursing curriculum (Huggins et al., 2018; Lim et al., 2020) with skills and knowledge further developed during new-graduate transition and post-graduate programmes (Foster et al., 2013; Patterson et al., 2008). The MSE is a structured assessment positioned as a sub-section within a comprehensive mental health assessment framework (Coombs et al., 2011). The MSE facilitates the collection of subjective and objective data based on clinical observations and consumers' lived experiences which depict their current mental state at that moment in time (Sadock et al., 2017). The MSE takes place upon first contact with the consumer and is repeated at subsequent engagements allowing for ongoing assessment, observation, and evaluation of their mental state (Assadi, 2020).

The MSE is undertaken in the context of an interview assessment under the domains of appearance, behaviour, speech, mood, affect, thought form and content, perception, cognition, insight, and judgement (Ebert, 2019). Subjective experiences and objective descriptions from the MSE are methodically analysed and interpreted for the purposes of facilitating diagnosis, pharmaceutical interventions, ongoing evaluation, and healthcare communication (McAllister-Williams et al., 2016). However, inconsistencies and insensitivities have been reported regarding interview assessment processes. For example, consumers have described interview assessments as repetitive, generating feelings of disempowerment and marginalization (Hamilton et al., 2004; Hird, 2007; Ziółkowska, 2009). Consumers admitted under the mental health legislation were subjected to coercive nursing interventions with little involvement in decision making regarding care and treatment (Akther et al., 2019). The lack of involvement perpetuated feelings of disempowerment, dehumanization (Akther et al., 2019) and a desire to re-engage with the interview assessment process to either seek clarifications about what was discussed, express their thoughts in a different way, or seek a different outcome

(Hird, 2007). Lived experiences of mental health assessments have been described by consumers as 'being stopped in the street by a market researcher, oh answer these questions and goodbye' (Hird, 2007, p. 1568) including 'not being listened to', lack of involvement in 'decision making', lack of 'trust... epistemic trust' and absence of therapeutic alliance (Lawn et al., 2021, p. 8).

The MSE is a fundamental nursing intervention in acute in-patient mental health settings (Foster et al., 2021). Nurses cannot provide 'valid and reliable forms of nursing care without valid and effective assessment' (Barker, 2004, p. 6). Subjective experiences and objective observations are vital for use as a reference point and baseline in comparing changes in the mental state of the consumer (Cihlar, 1986). However, the MSE is distinct from any other assessment (Huline-Dickens, 2013) as there is no standard method or procedure in the application of the MSE (Neto et al., 2019). Conducting a MSE necessitates knowledge of psychopathology (Blaabjerg et al., 2020), including engagement and observational skills, and the ability to build positive therapeutic alliance within a culturally sensitive approach (Bhugra et al., 2018).

Nurses across diverse settings with different nursing roles may use and conduct the MSE differently. For example, inconsistencies in conducting and interpreting MSE findings across diverse socio-cultural environments have been reported (Manjunatha et al., 2008). Language barriers may interfere with the conduct of a thorough MSE and may lead to an incomplete or distorted MSE including challenges in developing therapeutic alliance (Bauer & Alegría, 2010). In addition, the distinction between subjective and objective phenomena has been emphasized as being problematic (Huline-Dickens, 2013). For example, Neto et al. (2019) contend the notion of translating MSE subjective experiences into objective data is unreliable. This can pose a concern for a person's safety and the safety of others, considering the application of the MSE is used as an assessment framework which allows for further assessments to take place such as risk assessment for the presence of thoughts and behaviours of self-harm (Crawford et al., 1998) harm to others (Soltan & Girguis, 2017) suicide, and risk of violence to others or objects (Shergill & Szmukler, 1998).

Nurses' expertise in conducting the MSEs has been described as a vital component of a person's treatment planning as it informs clinical decisions, nursing diagnosis, care planning, implementation, and evaluation of care (O'Brien et al., 2008). However, conducting an MSE can often be time-consuming. While it is imperative for the MSE not to be rushed (Bhugra et al., 2018) nurses in acute in-patient mental health settings spend little time in direct contact with consumers (Glantz et al., 2019). Similarly, nurses working in EDs spend 3 minutes per nursing activity with each person in their care (Fann et al., 2019). Lack of time spent with consumers makes it difficult for nurses to establish



a therapeutic alliance which is essential for building trust (Zetterberg et al., 2022) when gathering subjective and objective data during the MSE process. This generates potential concerns in relation to consumer safety (Glantz et al., 2019). For example, consumers may sense the rush, therefore, provide brief MSE answers, and suppress spontaneous comments which may contain valuable information such as potential self-harm or suicide risk (Harris et al., 2019).

A critical but often neglected aspect of the MSE is the documentation of the subjective and objective information collected during the engagement with the consumer (Cihlar, 1986). This could be due to the MSE documentation lacking a structured format including uncertainty in the subdivision of the MSE domains suggesting the MSE domains lack theoretical bases explaining how they were established and subdivided into a set of assessable 'mental functions' (Neto et al., 2019, p. 3). Despite the complexities of the MSE, the need for nurses' knowledge and skills in areas such as psychopathology, engagement, and observation, accurately ascertaining subjective and objective information and using the information within clinical care have been warranted (Clinton & Hazelton, 2000; Hellwig, 1993; Nursing and Midwifery Board, 2021; Rees, 2021). There are several qualitative and quantitative studies that consider the MSE (Cleary et al., 2005; Heslop et al., 2016; Sands et al., 2013); however, there is a paucity of comprehensive reviews which examine nurses' experiences when conducting the MSE.

Systematic and integrative review methods were considered during the initial search of the literature. Arksey and O'Malley (2005) scoping review methodology was chosen over a systematic or integrative review due to the aim of the review and the broad nature of the research question given the landscape of research related to nurses' experiences when conducting the MSE is not known.

AIM

The aim of this scoping review is to identify, examine and summarize the available literature relating to nurses' experiences when conducting the MSE.

METHODS

A scoping review was conducted to identify, examine, and summarize the available literature which focused on nurses' experiences when conducting the MSE. Arksey and O'Malley (2005) scoping review framework consisted of an iterative five-step process: (i) identifying the research question, (ii) identifying relevant studies, (iii) study selection, (iv) charting the data, (v) collating, summarizing and reporting the results. SV conducted a preliminary search through databases which demonstrated

a paucity of literature available related to nurses' experiences when conducting the MSE. Scoping reviews are a common method when broadly searching the literature on a specific topic where different study designs might be pertinent 'especially where an area is complex or has not been reviewed comprehensively before' (Arksey & O'Malley, 2005, p. 21). Thus, performing a scoping review was relevant as it offered a methodological structure for investigating the extent, range and nature of the literature and identify gaps about nurses' experiences when conducting the MSE. This review considered research articles published in peer-reviewed journals including grey literature which were accessed and sourced via library databases.

Quality check

In line with the PRISMA Extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018) the author elected to conduct an optional sixth step which allowed for quality testing of the articles included in the review. Therefore, to integrate relevant criteria for quantitative and qualitative methodologies, the 12 articles were read systematically using a modified quality assessment checklist adapted from Walsh and Downe (2006) and Downe et al. (2007) and based on the Critical Appraisal Skills Programme (CASP) tool (CASP, 2023). The following headings were therefore considered and included: clear statement of aims, methodology and methods, research design, recruitment and sampling strategies, data collection, research reflexivity, ethical considerations, data analysis, rigour, validity and reliability, findings/results, and value of research. Number of checks, including article grading such as A, B, C or D was applied. Articles that rated as A or B were included in the review. No records were removed after undergoing quality testing. Detailed quality ratings for the final 12 articles are presented in Table 1.

Step 1: Identify the research question

The first stage of conducting the scoping review was identifying the research question. Identifying the research question informed the development of strategies used to guide the literature search process. The research question for this scoping review was 'What are nurses' experiences when conducting the MSE?'. Initially, a broad preliminary review of the literature was conducted. Preliminary review of the literature revealed a need for key concepts of the review to be refined and clearly articulated. For example, Peters et al. (2020) framework was implemented to inform the search strategy. The application of population, concept and context (PCC) framework provided a robust structure in developing congruence between the scoping review title, review question and the inclusion criteria (Peters et al., 2020; Table 2).



TABLE 1 Quality check.

Article	Clear statement of aim/purpose	Methodology/Methods	Research design	Recruitment/sampling strategy	Data collection	Research reflexivity	Ethical consideration	Data analysis, rigour, validity, and reliability	Findings/results	Value of research	n	Overall quality rating
Cleary et al. (2005)	✓	X	✓	✓	✓	X	✓	✓	✓	✓	8	B
Coombs et al. (2013)	✓	✓	✓	X	✓	X	✓	✓	✓	✓	8	B
Heslop et al. (2016)	✓	✓	X	X	✓	X	✓	✓	✓	✓	7	B
Jelinek et al. (2013)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9	A
Kerrison and Chapman (2007)	✓	✓	✓	✓	✓	X	X	✓	✓	✓	8	B
Kudless and White (2007)	✓	✓	✓	✓	✓	X	X	✓	✓	✓	8	B
Mullen et al. (2013)	✓	X	✓	X	✓	X	✓	✓	✓	✓	7	B
Puyat et al. (2019)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	7	B
Sands (2007)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9	A
Sands et al. (2013)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9	A
Sivakumar et al. (2011)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9	A
Zeeman et al. (2002)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	9	A

Note: Quality assessment checklist: an adaptation of the Critical Appraisal Skills Programme CASP tool (CASP, 2023; Downe et al., 2007; Walsh & Downe, 2006). Key to ratings: ✓ = Detailed coverage of screening question; * = Screening question covered but not detailed; X = Screening question not addressed; n = number of checks. Overall quality rating: A = Nil or few flaws, the study credibility, transferability, dependability, and confirmability is high; B = some flaws, unlikely to affect the credibility, transferability, dependability, and/or confirmability of the study; C = some flaws which may affect the credibility, transferability, and/or confirmability of the study; D = significant flaws which are very likely to affect the credibility, transferability, dependability and/or confirmability of the study (Downe et al., 2007, p. 132).



Step 2: Identify relevant studies

To ensure a comprehensive search was undertaken to identify the available literature suitable to answer the research question, an initial search was carried out in CINAHL. Thus, the search strategy was then applied to the following six databases: APA PsycInfo, CINAHL, MEDLINE, PubMed, ProQuest and Scopus. Google Scholar, Trove and Proquest Dissertation were also searched for grey literature. To capture a broader range of available literature related to nurses' experiences when conducting the MSE, no date limitation was applied. Boolean operators and truncations were used for search terms (Table 3).

Step 3: Study selection

The initial abstract and title screening identified 1250 records. A further five records that met the inclusion criteria were sourced by hand searching the included studies' reference lists. Duplicates (294) were removed, and 956 records were screened of which 865 records were excluded and 91 were full text reviewed. There were 79 records considered outside of the scope of interest. Twelve studies met the inclusion criteria for this scoping review. The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) flow diagram was used to map the search process (Page et al., 2021; Figure 1).

Inclusion criteria

Two reviewers SV and GM independently screened the titles and abstracts against the inclusion criteria: primary peer-reviewed articles related to nurses with experiences of conducting the MSE. Studies without available abstracts or full texts were requested via a

library document delivery request process. The review considered quantitative, qualitative, and mixed-method study designs related to nurses' experiences of the MSE. For the purpose of this scoping review and inclusion and exclusion criteria, a nurse has been defined as an individual who has completed a tertiary nursing education programme, is registered with their local regulatory organization, can demonstrate competence to practice and provide direct nursing care to individuals across the lifespan within diverse healthcare settings (Nursing and Midwifery Board of Australia, 2016). In addition, a credentialed mental health nurse is defined as a registered nurse who holds a recognized specialist qualification in mental health nursing (Australian College of Mental Health Nurses, 2023).

Exclusion criteria

Studies were excluded if findings included:

- The Mini-Mental State Examination (MMSE)
- A modified MSE to screen and measure cognitive impairment (e.g. dementia and/or delirium)
- The experiences of the MSE by other health professionals (e.g. psychiatrists)
- The MSE for undergraduate or postgraduate educational purposes (e.g. nursing students)

Step 4: Charting the data

A data charting table was developed to enter the key items of information obtained from the included studies. The following key characteristics were charted: author/s, year, country, aim/purpose of the study, context, design, and key findings relevant to the review question (Table 4). Data charting was completed independently by SV.

TABLE 2 PCC framework for identifying concepts of the scoping review.

PCC element	Definition
Population	Nurses
Concept	Experiences with the Mental State Examination (MSE)
Context	Any context (community nursing, mental health and general in-patient hospital settings, emergency departments, residential aged care facilities, and in any country)

TABLE 3 General outline of the search strategy.

Population	AND	Concept	AND NOT	Concept	AND	Context
'Mental health nurse'		MSE OR 'mental state examination'		'Mini-mental state examination'		Any
OR		OR 'mental status examination'		OR 'mini-mental status examination'		
'psychiatric nurse'		OR 'mental state assessment'		OR 'mini-mental state'		
OR		OR 'mental status assessment'		OR 'mini-mental status'		
nurs*		OR 'mental state exam'		OR 'mini-mental status'		
OR 'psychiatric nursing'		OR 'mental status exam'		OR MMSE		
OR		OR 'mental health assessment'				
'mental health nursing'						

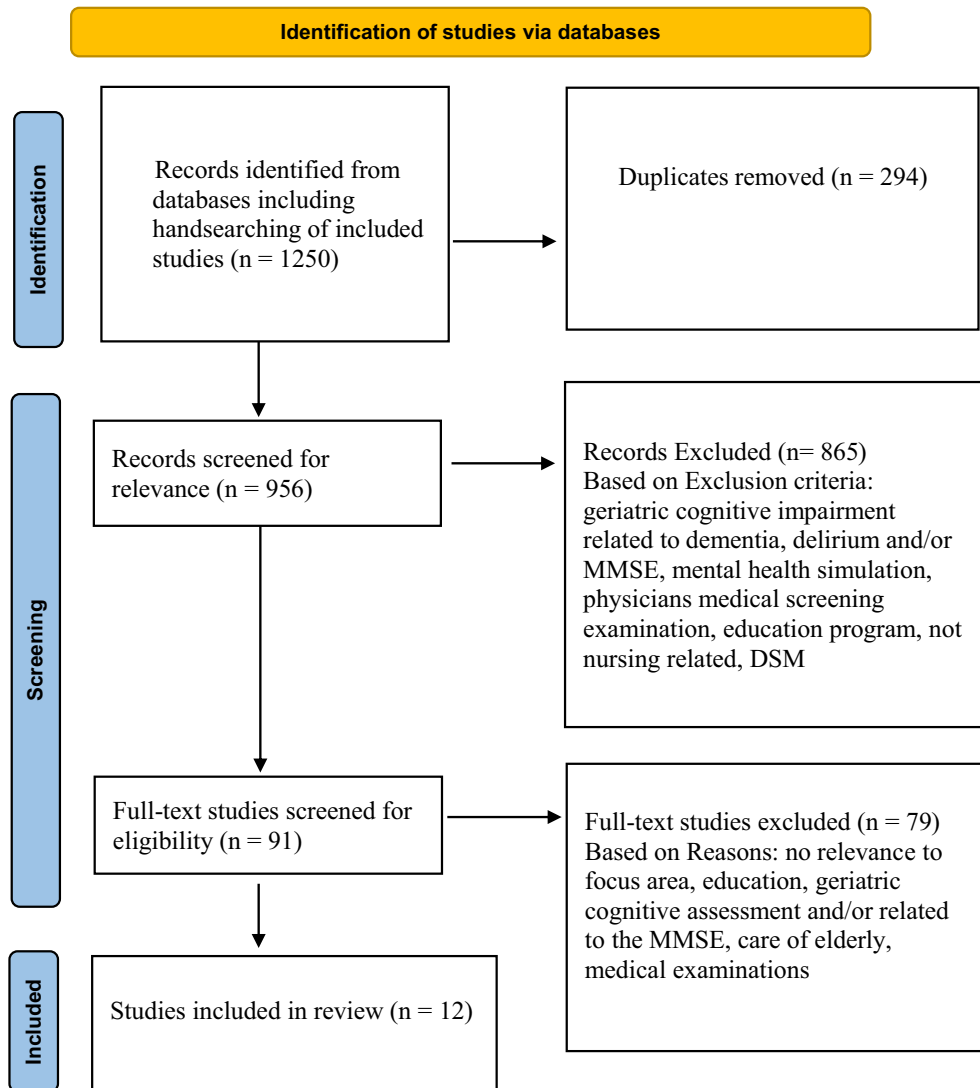


FIGURE 1 PRISMA flow chart for the scoping review (Page et al., 2021).

Step 5: Collating, summarizing, and reporting the results

To present a narrative account of the existing literature, the author read each paper in detail. Information pertinent to the aim and question of the review was extracted and placed in a data charting table (Table 4). Findings from other disciplines (e.g. doctors) were excluded from data analysis. Findings were thematically coded and summarized by SV and reviewed by GM, LL, RL and GD. Three themes were identified across the selected studies (see Tables 5 and 6).

RESULTS

Twelve articles were identified for this scoping review. Studies were undertaken in the United States (n=1), Canada (n=1) and Australia (n=10). The year of publication ranged from 2002 to 2019. Study designs were

quantitative (n=3), qualitative (n=4) and mixed methods (n=5). Three themes were identified concerning nurses' experiences with the MSE in diverse health care settings. *Theme 1: Nurses' role and the MSE* explains nurses' experiences with the MSE as a frequently used assessment in nursing across diverse settings. *Theme 2: Nurses' competence and knowledge when conducting the MSE* depicts various challenges nurses experience in conducting the MSE, and *Theme 3: Nurses' confidence when conducting the MSE* describes varied levels of confidence nurses experienced in conducting the MSE.

Nurses' demographics across the 12 included studies were analysed. Nurse participants were from the United States, Canada, and Australia. The service settings were four in-patient mental health settings (Coombs et al., 2013; Mullen et al., 2013; Puyat et al., 2019; Sands et al., 2013), five community mental health settings (Coombs et al., 2013; Heslop et al., 2016; Kudless & White, 2007; Sands, 2007; Zeeman et al., 2002), and three in EDs (Jelinek et al., 2013; Kerrison & Chapman, 2007; Sivakumar



TABLE 4 Data charting table.

Author, year, country	Aim/purpose	Context	Methodological design	Sample population	Data analysis	Key findings	Theme coding
1 Cleary et al. (2005), Australia	To ascertain the experience and views of mental health nurses, working in hospitals in an area mental health service. The focus was to establish nursing care delivery in those settings	Acute in-patient mental health setting	Quantitative (surveys/Questionnaire)	250 nurses working in in-patient mental health settings were invited to complete a survey. 118 (47%) surveys were returned	Descriptive statistics	<ul style="list-style-type: none"> Having community experience was associated with increased confidence in performing MSEs Nurses with community experiences rated the importance of and confidence in undertaking MSE higher than those without previous community placements 	Confidence
2 Coombs et al. (2013), Australia	To explore how mental health nurses describe the content of a comprehensive mental health nursing assessment. Aimed to understand the content and process of a comprehensive mental health nursing assessment	Acute in-patient mental health community mental health setting	Qualitative modified grounded theory approach (interviews)	18 mental health nurses, ranging from new graduates (less than 12 months) to experienced nurses (greater than 20 years), clinicians and managers working in either inpatient ($n = 8$) or ambulatory community settings ($n = 10$)	NVivo 7 software is used to support analysis with the initial coding and identification of themes	<ul style="list-style-type: none"> Of the 18 participants, six (33.33%) mentioned the MSE as areas of mental health nursing assessment Not all MSE domains were screened for. The most common MSE domains screened were appearance (body language) 27.78% ($n = 5$), speech 11.11% ($n = 2$), behaviour 22.22% ($n = 4$), orientation 16.67% ($n = 3$), hallucinations/delusions 38% ($n = 7$), including mood 38.89% ($n = 7$) 	Competence and knowledge
3 Heslop et al. (2016), Australia	To identify the components of the community mental health nursing role and to quantify the time nurses spent in each component during the study period	Community mental health setting	Qualitative (focus groups)	13 clinical nurses and 4 clinical nurse specialists	Content analysis	<ul style="list-style-type: none"> Role of the community mental health nurse was to conduct comprehensive mental state examinations Community mental health nurses spent 79.5h (or 5.2% of the total 1528 h (4-week period) conducting mental state assessments 	Nurses' role
4 Jelinek et al. (2013), Australia	To better understand ED staff knowledge and levels of confidence in treating people with mental health-related problems using qualitative methods	Emergency Department	Qualitative learning needs analysis (Semi-structured telephone interviews)	20 doctors and 16 nurses	Thematic framework analysis	<ul style="list-style-type: none"> Nurses perceived knowledge gaps in conducting Mental Status Assessment such as describing the difference between delusions and hallucinations 	Competence and knowledge



TABLE 4 (Continued)

Author, year, country	Aim/purpose	Context	Methodological design	Sample population	Data analysis	Key findings	Theme coding
5 Kerrison and Chapman (2007), Australia	To determine the current concerns that nursing staff had in caring for patients who present to a general hospital ED with a mental illness	Emergency Department	Qualitative (purposeful/snowballing sampling, Semi-structured focus group interviews)	Non-mental health trained emergency nurses—senior non-mental health trained emergency nurses	Content analysis	<ul style="list-style-type: none"> Participants considered that ED nursing staff had varying levels of competence and confidence, particularly in performing MSEs. Lack of confidence and reluctance to ask patients confronting and probing questions. Some ED nurses actively avoided patients perceiving them to be social or behavioural problems, preferring 'real patients' such as trauma victims. Some staff penalized 'bad behaviour' by allocating lower triage scores and making the patient wait longer for treatment 	Confidence Competence and knowledge
6 Kudless and White (2007), United States	To compare the competencies of basic level and advanced practice nurses with psychiatric-mental health nursing competencies and to assess the nurses' roles and division of work time	Community mental health setting	Quantitative (Survey)	38 community mental health nurses were sent surveys. 32 returned the survey (80% return rate)	Descriptive statistics	<ul style="list-style-type: none"> The MSE was an intervention performed by community mental health nurses across treatment programmes 	Nurses' role
7 Mullen et al. (2013), Australia	To implement and evaluate the care zoning model in an eight-bed psychiatric intensive care unit and, specifically, to examine improvement with the documentation and communication of clinical risk assessment and management	PICU, acute in-patient mental health setting	Mixed methods (implementation trial framework; survey, medical record audit tool; weekly staff consultations/ meetings)	In-patient mental health nurses	SPSS-Analysis of variance (ANOVA)-based techniques	<ul style="list-style-type: none"> Quality of MSEs improved. Improved accuracy of information regarding mental state. Much more care in documenting information, particularly the MSE. Clear improvement in knowledge and understanding of the MSE and presenting symptoms. Improvement in 1:1 time spent with patients which was linked to the successful increase in the completion of MSEs on the care zoning form. Nurses spent more time with patients to more effectively assess and complete their MSE 	Competence and knowledge

(Continues)



TABLE 4 (Continued)

Author, year, country	Aim/purpose	Context	Methodological design	Sample population	Data analysis	Key findings	Theme coding
8 Puyat et al. (2019), Canada	To characterize the in-patient care received by individuals experiencing early psychotic episodes in an inner-city hospital	Acute in-patient mental setting	Quantitative (medical records)	73 medical in-patient records (102 care episodes and an average length of stay of 32.6 days)	Descriptive statistics	<ul style="list-style-type: none"> MSEs that are expected to be performed by a nurse once per shift were conducted in only 18.6% of the care episodes MSEs were performed at least once during the inpatient stay. However, the consistency in performing the MSE was low 	Nurses' role
9 Sands (2007), Australia	To produce a comprehensive, holistic definition and health triage nursing in Victoria	Mental health telephone triage services	Mixed method	Mental health triage nurses	Descriptive analysis Content analysis	<ul style="list-style-type: none"> Mental health triage practice primarily involves point-of-entry mental health assessment and includes core activities, such as conducting mental status examination 	Nurses' role
10 Sands et al. (2013), Australia	To identify the core competencies of mental health telephone triage, including key role tasks, skills, knowledge, and responsibilities, in which clinicians are required to be competent to perform safe and effective triage	Mental health telephone triage services	Mixed Methods (observational design)	18 mental health triage clinicians, comprised of 16 nurses and two social workers	Descriptive analysis Content analysis	<ul style="list-style-type: none"> MSE identified as a core competency in the mental health telephone triage assessment. Use more prescriptive or directive types of questions during MSE to seek specific information about the history of the problem and psychiatric signs and symptoms. Not all items of MSE were routinely screened for at triage As part of the process of MSE, (77.1% of participants sought information about current and past risks, for example, risk most frequently assessed self-harm/suicide, risk of harm to others. Planning and action-once sufficient information has been gathered from the caller to inform MSE, the clinician considers consumer's service needs 	Confidence Nurses' role



TABLE 4 (Continued)

	Author, year, country	Aim/purpose	Context	Methodological design	Sample population	Data analysis	Key findings	Theme coding
11	Sivakumar et al. (2011), Australia	To identify the mental health-related learning needs of doctors and nurses working in Australian EDs	Emergency Department	Mixed Method (survey)	109 nurses (quantitative) 102 nurses (qualitative)	Statistical analysis Content analysis	<ul style="list-style-type: none"> 15/109 nurses were never confident, 32/109 were rarely confident, 41/109 were sometimes confident and 2/109 always confident 16/109 ED nurses self-rated as having poor ability in conducting the MSE, 28/109 had fair ability, 38/109 had average ability, 17/109 had good ability and 2/109 nurses rated themselves as having excellent ability in conducting an MSE 102/109 ED nurses reported knowledge deficits in conducting an MSE Knowledge/skill deficits related to MSE 	Confidence Competence and knowledge
12	Zeeman et al. (2002), Australia	To obtain information regarding the current role of the community mental health nurse (CMHN)	Community mental health setting	Mixed Method (questionnaire)	12 community mental health nurses	Descriptive statistics Qualitative data analysis	<ul style="list-style-type: none"> 15.3% of nurses reported conducting an informal MSE on a client as an aspect of care most often identified Only 4% of nurses completed formal MSE 	Nurses' role

**TABLE 5** Overview of scoping review themes.

Article	Nurses' role and the MSE	Nurses' competence and knowledge when conducting the MSE	Nurses' confidence when conducting the MSE
Cleary et al. (2005)			X
Coombs et al. (2013)	X	X	
Heslop et al. (2016)	X		
Jelinek et al. (2013)		X	
Kerrison and Chapman (2007)		X	X
Kudless and White (2007)	X		
Mullen et al. (2013)		X	
Puyat et al. (2019)	X		
Sands (2007)	X		
Sands et al. (2013)	X		X
Sivakumar et al. (2011)		X	X
Zeeman et al. (2002)	X		

TABLE 6 Exemplar of thematic grouping.

Theme: Nurses' competence and knowledge when conducting the MSE		
Associated articles	Findings/extracts	Codes
Coombs et al. (2013)	Of the 18 participants, 6 (33.33%) mentioned the MSE as areas of mental health nursing assessment	Lack of knowledge and understanding of the MSE
Jelinek et al. (2013)	Nurses perceived knowledge gaps in conducting Mental Status Assessment such as describing the difference between delusions and hallucinations	Knowledge gaps of the MSE
Kerrison and Chapman (2007)	Nurses had varying levels of competence and knowledge, particularly in performing mental state assessments	Varying levels of competence and knowledge of the MSE
Mullen et al. (2013)	Formalizing the MSE improved knowledge and understanding of the MSE and presenting symptoms	Improved knowledge and understanding of the MSE
Sivakumar et al. (2011)	102/109 ED nurses reported knowledge deficits in conducting an MSE	Knowledge deficit of the MSE

et al., 2011). Three of the studies were undertaken using both in-patient and community mental health settings (Coombs et al., 2013; Sands, 2007; Sands et al., 2013) of which two studies were undertaken in hospital emergency Crisis Assessment and Treatment Teams (CATT) (Sands, 2007; Sands et al., 2013). Across the 12 studies, a total of 339 nurses participated, of which 72 were community mental health nurses (Coombs et al., 2013; Heslop et al., 2016; Kudless & White, 2007; Sands, 2007; Zeeman et al., 2002), 142 were in-patient mental health nurses (Cleary et al., 2005; Coombs et al., 2013; Mullen et al., 2013; Puyat et al., 2019; Sands, 2007), and 125 ED nurses (Jelinek et al., 2013; Sivakumar et al., 2011). Further, 129 were female nurses and 56 were male. Nurse qualifications ranged from hospital trained to a bachelor's and master's degree and PhD. Years of experience varied from new-graduate nurses with less than 1 year of experience to experienced nurses with over 20 years. The nurse's roles varied between mental health and non-mental health trained ED nurses, to management and administrative roles, including mental health case

managers, mental health clinical nurse specialists, and mental health nurse practitioners.

Theme 1: Nurses' role and the MSE

Five of the 12 studies included in this review identified the MSE as a component of the mental health nursing role (Coombs et al., 2013; Heslop et al., 2016; Kudless & White, 2007; Puyat et al., 2019; Zeeman et al., 2002). An Australian study conducted by Heslop et al. (2016) aimed to identify components of the community mental health nursing role in a public mental health service. Nurse participants described the MSE as one of 18 core components of the community mental health nurse role (Heslop et al., 2016). To further examine the community mental health nurse's role and workload allocation, Heslop et al. (2016) measured the time nurses spent undertaking each component within their clinical roles. For example, community mental health nurses reported, over a 4-week (1528 h) period they spent 79.5 h (5.2%) of their allocated



time conducting MSEs (Heslop et al., 2016). Zeeman et al. (2002) study resonates with similar findings, over a 5-day period in direct contact with consumers in the community, 15.3% of nurses conducted an informal MSE as a core aspect of nursing care with only 4% of nurses completing a formal MSE. Similarly, the MSE was identified as the most frequently mentioned area of assessment in acute in-patient and community mental health settings (Coombs et al., 2013; Puyat et al., 2019), while Kudless and White (2007) described the MSE as a nursing intervention performed by community mental health nurses across treatment programmes such as crises management.

Two studies identified the MSE as a core aspect of mental health telephone triage (Sands, 2007; Sands et al., 2013). Sands's (2007) study aimed to provide a comprehensive definition and description of mental health nursing telephone triage. Nurses in Sands (2007) study revealed that mental health nursing telephone triage primarily includes core activities such as conducting MSEs. Similarly, in a mixed methods study, findings from Sands et al. (2013) identified the MSE as one of seven core practices essential in performing an effective and safe mental health telephone triage. In contrast, one study reported nurses lacked consistency when conducting and documenting the MSEs in acute in-patient mental health settings (Puyat et al., 2019). MSEs expected to be conducted by a nurse once per shift were completed in only 18.65% of all care episodes with some evidence of MSE documentation (Puyat et al., 2019). Two studies Sands et al. (2013) and Coombs et al. (2013) identified that nurses did not routinely apply all MSE domains. For example, the most common MSE domains screened by nurses were appearance, speech, behaviour, orientation, altered perception such as hallucinations and delusions, including mood (Coombs et al., 2013).

Theme 2: Nurses' competence and knowledge when conducting the MSE

Nurses had varying levels of competence, knowledge and understanding of the MSE due to their level of education and training. Three Australian studies were undertaken in EDs (Jelinek et al., 2013; Kerrison & Chapman, 2007; Sivakumar et al., 2011). To identify ED nurses' mental health-related learning needs, Sivakumar et al. (2011) surveyed 109 ED nurses of which the majority did not feel competent to undertake an MSE. Sixteen (15.8%) out of 109 ED nurses reported themselves as having poor ability in conducting the MSE, including 37.6% ($n=38$) of participants who rated average ability. Only 2% ($n=2$) of nurses rated themselves as having excellent ability in conducting an MSE. Studies by Sivakumar et al. (2011) and Jelinek et al. (2013) reported knowledge deficits for nurses when conducting an MSE; 'It's just

the lack of knowledge... like what is the real ... difference between delusions and hallucinations and stuff, we get a bit stuck on' (Jelinek et al., 2013, p. 4). Kerrison and Chapman (2007) reported nurses had varied levels of competence in conducting the MSE generating feelings such as feeling 'ill-equipped' to triage, assess and manage consumers (p. 52). The findings are similar in acute in-patient and community mental health settings. Coombs et al. (2013) reported six out of the 18 (33.33%) nurses working in acute in-patient and community mental health settings identified the MSE as a component of a comprehensive mental health nursing assessment. They found nurses experienced hesitancy and difficulty in answering the interview questions. For example, the study identified challenges related to the application, knowledge and understanding of the MSE in mental health nursing practice across both community mental health settings and acute in-patient mental health nursing settings. Coombs et al. (2013) found that nurses were provided with an example of a MSE domain while other nurses commenced answering the interview questions with classic aspects of the MSE such as appearance and behaviour, but then spoke of risk, past behaviours, and suicide. For example, '... their appearance, behaviour, orientation, and demeanour... it would include things like risk assessment, past behaviours, vulnerability, suicide, aggressiveness, physical state, and domestic violence issues'. However, participants did not elaborate further (Coombs et al., 2013, p. 153).

One study reported nurses' knowledge and understanding of the MSE improved with the introduction of a formalized and structured approach when conducting and documenting the MSE (Mullen et al., 2013). The improved knowledge and understanding of the MSE enhanced clinical practice. For example, nurses spent more 1:1 time with consumers to conduct and complete the MSE, the accuracy of gathering subjective and objective data, and MSE clinical documentation improved. Furthermore, the application of a structured process when conducting the MSE enhanced nurses' ability to monitor for alterations in mental state (Mullen et al., 2013).

Theme 3: Nurses' confidence when conducting the MSE

Nurses working in acute in-patient mental health settings and community mental health settings reported higher confidence levels in conducting the MSE (Cleary et al., 2005) in comparison to nurses working in EDs who lacked confidence (Kerrison & Chapman, 2007; Sivakumar et al., 2011). Fifteen out of 109 ED nurses rated themselves as never confident, 41/109 nurses rated as sometimes confident with only 2/109 nurses rating as always confident in conducting the MSE (Sivakumar et al., 2011). The low rating of confidence in conducting the MSE by ED nurses was a result of paucity



of education and training (Kerrison & Chapman, 2007; Sivakumar et al., 2011) and availability of resources (Jelinek et al., 2013). Experience as a mental health nurse in the community setting was linked to higher levels of confidence with the MSE. Cleary et al. (2005) identified that nurses working in acute in-patient mental health settings with previous experiences in community mental health settings had higher levels of confidence in conducting the MSE compared to nurses with no experience in community mental health settings. Further, in Cleary et al. (2005) study, nurses with previous community mental health setting experience rated the importance of conducting MSEs higher than those nurses without community mental health experience.

Varying attitudes and behaviours related to the MSE were apparent when considering both ED nurses and mental health telephone triage nurses. Kerrison and Chapman (2007) aimed to determine ED nurse's concerns in caring for consumers who presented to EDs with a mental illness. Nurses' lack of confidence in conducting the MSE led to a reluctance to ask consumers confronting and probing questions (Kerrison & Chapman, 2007). For example, nurses actively avoided consumers, perceiving them to present with social or behavioural problems, preferring 'real patients' such as trauma victims (p. 52). This resulted in some nurses seeking to penalize 'bad behaviour' by assigning lower triage scores and making consumers wait longer for treatment (Kerrison & Chapman, 2007, p. 52). However, unlike Kerrison and Chapman (2007), Sands et al. (2013) found mental health telephone triage nurses actively used the MSE as a framework. They applied greater perspective and directive questions to elicit information about the consumers' presenting problem and associated urgency. Seventy-seven per cent of the participants in the study by Sands et al. (2013) used the MSE to obtain information about current and past risks of self-harm, suicide and risk of harm to others. Fundamentally, they used the MSE to guide the care planning process, the need for treatment and appropriate service provision.

DISCUSSION

The aim of this scoping review was to identify, examine and summarize the available literature relating to nurses' experiences when conducting the MSE. The review identified that nurses with previous community mental health setting experience had higher confidence levels in conducting the MSE and rated the importance of conducting MSEs higher than those nurses without community mental health experience (Cleary et al., 2005). These findings are consistent with those from Elsom et al. (2008) who found confidence to be linked to the expansion of the role of nurses working in community mental health settings. For example, 90%

or 138 of 154 nurses working in mental health community settings felt confident to conduct assessments and make recommendations for involuntary treatment. However, an increase in confidence levels when conducting MSEs for in-patient mental health nurses was linked to and reported as high during the completion of a transition programme into mental health nursing (Cleary & Happell, 2005).

The review suggests that deficits in knowledge and understanding of the MSE created negative attitudes and behaviours in nursing care practices (Kerrison & Chapman, 2007). Similar findings are reported by Sahile et al. (2019). Sahile et al. (2019) found nurses' lack of mental health education, knowledge and training were significantly associated with negative attitudes and discriminatory behaviours towards consumers in Public Health Care (PHC) settings. The review further identified nurses' lack of education and training in conducting MSEs led to a decrease in competence (Sivakumar et al., 2011). This finding supported the work of Sharrock and Happell (2007) who found that educational preparedness at an undergraduate level was associated with care competence. Lack of competence in nursing care can lead to nursing errors and directly impact the safety and overall health and well-being of the consumer (Smith, 2012). Oranye et al. (2016) and Ellis and Philip (2010) validate the importance of education as a key aspect in conducting the MSE. For example, nurses with post-basic nursing-related qualifications had higher competence in conducting the MSE in comparison to nurses without post-basic qualifications (Oranye et al., 2016). Rees (2021) stated nurses with knowledge of the MSE have the necessary skills to recognize deterioration in a consumer's mental health which in turn provides the foundation to reach out and seek appropriate support and make timely referrals to other health care disciplines.

The findings from one study in this review demonstrated that formalizing the MSE as a structured process increased nurses' knowledge and understanding of the MSE. Formalizing the MSE led to enhanced nurse-consumer engagement during the MSE process including improvement in the accuracy and quantity of MSE documentation (Mullen et al., 2013). These findings are supported by several other studies (Kareem & Ashby, 2000; Lobo et al., 2015; Mulhearn, 1989) which suggested the introduction of a structured MSE process significantly improved MSE clinical documentation. Such structured MSE formats were useful for nurses as they supported them to better identify consumers' needs and assisted in the systematic construction of care plans (Mulhearn, 1989). However, the acuity of the consumer's presentation may create challenges for nurses to conduct a structured MSE (Leigh & Streltzer, 2014). Wand et al. (2019) argue that the content and structure formats of current assessments require urgent review as they do not align with



contemporary thinking and best practice suggesting assessments should 'focus on identifying and addressing individual needs, not simply on screening for problems, risks, and arriving at an unscientific diagnosis' (p. 175). In addition, a recent study undertaken by Myklebust et al. (2018) elaborated on documentation models and how they place nurses in an expert position making it challenging for the consumer to be involved in the documentation process with many consumers expressing concerns about the content written about them in the progress notes. For example, essential aspects of nursing care related to recovery and person-centred care were not prioritized for documentation (Myklebust et al., 2018). Farrell (2015) emphasized that the MSE documentation records are filled with meaningless comments and descriptions. It, therefore, becomes apparent that this is an area of concern given that the MSE is used for clinical decision making (Wand et al., 2019) and dissemination of information amongst healthcare professionals (Meidrum, 2019), as Farrell (2015) stated, random collection of informal comments has the potential to cause harm rather than add value to the MSE.

This scoping review has identified the MSE as a component of the mental health nursing role and a core competency of mental health telephone triage services. In addition, others have described the MSE as a systematic approach in which a person's mental state can be assessed, observed, and evaluated (Ebert, 2019; Goldenberg & Chiverton, 1984; Kareem & Ashby, 2000; McAllister-Williams et al., 2016; Snyderman & Rovner, 2009; Trenoweth & Moone, 2017). For example, Johnston and Cowman's (2008) study revealed that 24% of referrals in a general hospital setting were a request for a Psychiatric Consultation Liaison Nurse (PCLN) to conduct an MSE, of which 75% of those referred for an MSE remained in hospital for 5 days or longer. Similarly, liaison nurses in Murphy et al. (2011) study were more considerate and cautious in conducting the MSE in EDs which led to identifying a higher rate of consumers who were at high risk of self-harm recurrence in comparison to psychiatrists. The findings of this review echo similar results. Findings from Sands et al. (2013) study identified the MSE as one of seven core practices essential in performing an effective and safe mental health telephone triage, including the MSE being used as a framework to obtain information about the current and past risk of self-harm, suicide, and risk of harm to others. However, a report prepared on behalf of the Australian Commission on Safety and Quality in Health Care (ACSQHC) by Gaslin and Dagley (2018) stated that currently there is no 'standardised process available for monitoring changes in a person's mental state' (p. ii). This raises questions about the application of the MSE and its reliability for the collection of subjective and objective data. As Tilly and Hoffman (1981) stated 'the MSE may be more

myth than method in contemporary psychiatry' (p. 564). Yet, the MSE remains a fundamental framework used in practice within mental health services and education worldwide (Foster et al., 2013; Lim et al., 2020; Neto et al., 2019; Xie et al., 2015).

This scoping review aimed to identify, examine, and summarize the available literature related to nurses' experiences when conducting the MSE. The review offered insights into nurses' experiences of conducting the MSE in diverse healthcare settings. More importantly, the review identified a gap in the body of knowledge pertinent to nurses' experiences when conducting the MSE which findings are used as a catalyst for further research.

Strengths and limitations

This review has several limitations. Literature relating to nurses' education of the MSE was excluded. Another limitation of the scoping review is that only articles published in English were included. While this scoping review has some limitations, it should be noted that it also has some notable strengths. Although Arksey and O'Malley (2005) highlighted scoping reviews do not require a critical appraisal, methodological quality of included studies was conducted using a quality assessment checklist. In addition, incorporating international papers within the review allowed for a range of primary peer-reviewed data to be captured.

CONCLUSION

This scoping review sought to obtain a comprehensive understanding of the research concerning nurses' experiences when conducting the MSE. The results of this scoping review identified the MSE as an assessment used in EDs, acute in-patient and community mental health settings, including mental health telephone triage services. Nurses working in EDs, and acute in-patient mental health settings experienced a lack of confidence and competence, including knowledge deficit in conducting the MSE in comparison to nurses working in community mental health settings. Consistency in conducting the MSE was low in acute in-patient mental health settings. When considering the consumer's needs for service, mental health telephone triage nurses used the MSE as a framework to seek specific information about the history of the problem and psychiatric signs and symptoms. In comparison, the lack of confidence led ED nurses to be reluctant to ask consumers confronting and probing questions, actively avoiding consumers, and assigning lower triage scores extending the waiting period for receiving treatment. Formalizing the MSE improved clinical practice, for example, increased nurses' knowledge and understanding of the MSE, and improved the time nurses spent with consumers when conducting the



MSE and MSE clinical documentation. Data from this scoping review suggests that confidence, competence, and knowledge are influenced by multiple factors. These factors include lack of education and training, availability of resources, structured approach in conducting and documenting the MSE, including the importance of, and increased confidence and competence in conducting MSE being associated with nurses' experiences of working in community mental health settings.

RELEVANCE TO CLINICAL PRACTICE

The review highlights the need for further research into nurses' experiences when conducting the MSE. Thus, further research is needed (i) to better understand nurses' experiences when conducting the MSE in acute in-patient mental health settings, (ii) to inform the development of policies and guidelines for the provision of evidence-based practice in relation to the MSE including (iii) the development of MSE educational and training programmes: as these seem to be neglected in contemporary mental health services particularly in acute in-patient mental health settings.

AUTHOR CONTRIBUTIONS

SV, LL, RE and GM from the School of Nursing and Midwifery, Western Sydney University, Sydney, Australia, and GD from the Department of Nursing, Midwifery and Health, Northumbria University, Newcastle-Upon-Tyne, United Kingdom for the critical revision of the paper for intellectual content. This review forms a component of the requirements for the completion of a Doctor of Philosophy for SV.

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CONFLICT OF INTEREST STATEMENT

There are no conflicts of interest to declare related to this scoping review.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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