

## Training matters

### Why psychiatric discharge summaries do not contain the mental state examination at discharge

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In an era where computerised information is dominant, it may seem an eccentric enterprise to assess the quality of case-notes and to propose changes in the notekeeping process. There are no institutional incentives for clinicians to provide organised and standardised clinical notes (Casper, 1987) and there is no clear evidence that poor notekeeping means that satisfactory care has not been provided.

On the other hand, there are some reasons to believe in the importance of well-kept case-notes. Increasingly, they are being recognised by clinicians as evidence for accountability rather than a mere instrument of communication between professionals (Vort & Mattson, 1989). Good case-notes can provide support when a psychiatrist is called upon to justify his or her actions in a medico-legal setting. They have been important in historical research, when the effects of booms, slumps, unemployment and wars have been associated with the incidence, nature and prognosis of psychiatric illnesses. There are also some advantages in using case-notes for teaching purposes. In addition it has been recommended elsewhere that case-note review could be the “best audit package” to be implemented currently by health districts.

These issues indicate that enhancing the quality of case-notes as a whole would be fully justifiable. However, the aim of this article is to concentrate on one section of case notes, the mental state examination, and to explore the possibility of using this item to assess changes within a course of psychiatric treatment.

#### *Mental state: a mirror of treatment?*

The mental state is the only section within the case notes which contains information capable of showing some degree of change within the course of treatment. In other words, it is the only section to demonstrate the results of clinical action.

Psychiatric treatment can involve a comprehensive set of long-term interventions, and positive results

are often not seen in a short period. If this is the case, a hospital admission is likely to represent only one segment of the whole process of treatment. On the other hand, if there is a convincing association between clinical practice and outcome, measuring changes within the course of a hospital stay might represent a proxy outcome measure for the whole process of the treatment.

To translate those assumptions into a process for medical audit we need two different measurement points within the course of the treatment, a mental state at admission and at discharge. It would be also necessary to establish quantitative criteria of what is expected regarding reduction of symptoms between these two points, bearing in mind the different clinical and demographic variables interfering with this reduction. A retrospective assessment of random selected discharge summaries could then be carried out documenting the changes in the mental state between admission and discharge by using existing rating scales or planning new ones. This framework meets one important precept of medical audit, namely “use of explicit criteria for measurement rather than implicit judgment”. Also it uses the existing audit strategy of randomly assessing case notes, but goes one step forward by providing proxy measures for outcome.

#### *Mental state examination and the real world*

Ellis *et al* (1987) sent questionnaires to the six consultants and nine junior doctors working at the psychiatric unit, asking their opinion of the importance of 263 items in the case history and, which of them should be recorded in detail by the end of the third inpatient day. There was an agreement of 100% among consultants and 92% among junior staff to include the items of the mental state section. Those figures can be contrasted with 15% and 18% for the physical examination items, 25% and 56% for presenting problems items, and also 37.5% and 15% for diagnosis and

formulation respectively for consultants and junior staff. An educational programme was set up and the authors assessed three different sets of case-notes in three different periods of time to review the degree of compliance which the case history outline developed. The mental state was the only section that showed significant rates of compliance and improvement in all three points of assessment. Recently, Craddock & Craddock (1990) examined 100 discharge summaries of a large psychiatric hospital and found that 71% of summaries contained an admission mental state as opposed to 25% for physical examination and 42% for past psychiatric history.

These findings lead us to think that the admission mental state possesses some attributes (consensus among clinicians of its importance, high frequency of reporting and susceptibility for improvement after an education process) that might qualify it to be the first point for measurement.

The next step is to look for our second point for measurement within the psychiatric treatment, that is, the mental state at discharge. However, it appears not to be a routine practice to report the mental state at discharge: Craddock & Craddock (1990) found that only 26% of the discharge summaries presented the discharge mental state.

The literature does not answer why mental state at discharge is less frequently recorded. We could speculate some reasons without empirical evidences to support them. First, classical psychiatric textbooks do not draw any attention to the necessity of a mental state at discharge; second, legal procedures require the mental state at admission but do not demand the mental state at discharge; and finally, the results of psychiatric treatment in a short period may be too slight and so discouraging clinicians to record them.

### Introducing changes

The structure of case notes in the health care field is sometimes assumed to be "an inevitable fact of life and therefore unalterable". Nevertheless, historical accounts show how intensively medical and psychiatric records have developed "from scratch marks on cave walls to the complex, legal, multipurpose document in use today" (Siegel & Fisher, 1981). These changes have not been detached from the history of medicine and health care: very often they have come about not for clinical necessity but through administrative or economic reasons. But since clinicians are the actual case-note reporters, any alteration not considered to have clinical utility is apt to fail once people "learn how to beat the system" (Siegel &

Fisher, 1981). Therefore, concentrating the assessment of the care on the information produced in the mental state examination at admission and at discharge may raise clinicians' interest in audit. Being clinical information, the core data for the assessment procedure, and not simply a mandatory completion of accountability documents, it allows audit through peer review.

Various criticisms are likely to be raised about the use of case notes as a source of evaluative data, the most cogent being the unsystematic and under-standardised way the information is recorded. Siegel & Fisher (1981) in their comprehensive book on records in mental health care see the psychiatric record "as a reflection of the care process in terms of its treatment orientation and standardisation of knowledge used to carry out the process". They see unstandardisation not as a characteristic of the psychiatric records in themselves but as a by-product of the lack of standardisation in psychiatry. Even when rigorously recorded data are used, there may be shortcomings in drawing rigorous inferences and conclusions.

However, for the mental state examination there is some standardisation on which items should be recorded since textbooks present similar frameworks on how to report them. This should allow the development of guidelines.

To conclude, it should be said that we are not trying to persuade anybody that audit through the mental state at admission and at discharge is a panacea to the ailments of audit in psychiatry. However, by presenting this proposal we are suggesting that a standardised mental state at admission and at discharge could open up new possibilities for audit, since it would make possible the detection of some sort of movement within the course of treatment.

### References

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*A full reference list is available on request from the authors.*