

ARCHIVAL DOCUMENTS AND ACCOUNTABILITY IN VICTORIA'S PSYCHIATRIC INSTITUTIONS

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For over a century Victoria's response to mental illness was primarily a custodial one. Recordkeeping played a key role in supporting the system of legal admission and detention that was the cornerstone of government-run psychiatric services. In the 1970s and 1980s legislators and service providers have sought to respond to medical and social changes by designing a broader psychiatric service and more diverse and rigorous accountability mechanisms. This paper explores the changes which this shift in emphasis has made to the role of recordkeeping in psychiatric institutions. Despite the climate of concern about the scope for human rights abuses within institutions, legislators have not seen records as an accountability mechanism but rather as an administrative addendum to psychiatric service delivery. However other accountability mechanisms including, most recently, clinical audit techniques have depended upon records and expected much of them. How does recordkeeping support service provision and accountability in psychiatric institutions? How has its role changed to meet the demands of new directions in accountability?

From the commencement of government-run mental health services in Victoria in the 1860s and at least until the 1960s the law was the foundation of the system of controlling, caring for and treating mentally ill people. Several related factors made this so. A limited number of options for successful intervention in psychiatric illness rendered institutionalisation, with its consequential emphasis on legal admission and detention, the primary form of care and control. As both a cause and a consequence of this, society drew strong links between mental illness and criminality and had little understanding of or sympathy for mental illness. Prevailing views of the boundaries of normal behaviour required that the institutions, and legislation which dealt with breaches of those boundaries, controlled the problem in whatever way possible.

Since the nineteenth century (and previously in Europe and America) every generation has rejected elements of conventional psychiatry and introduced an enlightened new way. Although I have not, in this case study, closely examined each piece of lunacy/mental health legislation operating in Victoria since the 1860s to determine exactly what new philosophy each embodies, an initial impression is that reforms have had a cyclical nature. In 1915, for example, the Victorian *Lunacy Act* distinguished for the first time between voluntary and involuntary admissions (the former being and remaining for many years relatively rare), and provided for trial leave for patients. Thus in the legislation at least a framework for rehabilitation was established. The 1959 *Mental Health Act*, however, whilst not undoing any earlier reforms, reaffirmed the role of mental health services in controlling mental illness and retardation by judicial admission and detention.

Similarly, the 1986 Victorian *Mental Health Act* is clearly the product of views about the role and scope of psychiatric services which are a rejection of many earlier policies. The Act reflects changes in attitudes which commentators have dated as beginning in the 1960s. In this decade a range of drugs, collectively known as psychotropic drugs, were introduced into clinical use. They offered a far more powerful form of treatment than any previously and provided an alternative means of controlling the behavioural effects of mental illness. At the same time, the civil rights movement drew society's attention to disempowered groups of people and demanded equity for them. For clients of mental health services this demand involved treatment rather than detention, community based care rather than institutionalisation and maximum protection against the infringement of individuals' liberty and self-determination. Conventional mental hospitals were disparaged, being seen as institutions of detention rather than treatment which served the needs of the community outside their walls rather than those members within.

By the late 1970s when a new *Mental Health Act* was first planned, several concerns had emerged out of the above climate. Firstly there was a need to de-emphasise involuntary detention, to design policies which assumed that mental illness was treatable and designated the government's role as the delivery of a psychiatric service, which was accessible by all and would not abrogate a client's liberty. Secondly, whilst de-emphasising institutional treatment, particularly involuntary institutional treatment, those who planned the new legislation also addressed community concerns that patients were legally protected against abuses such as continuing confinement without treatment or review, anonymous certification, and ignorance of their rights as patients.¹ Legislating for accountability in mental health services was not new. However revelations of psychiatric patient abuses in the early 1980s widened the definition of accountability. Traditionally the law had primarily attempted to regulate admission and discharge. Incidents in institutions for the mentally ill and intellectually disabled brought into question what happened in between, and in particular the adequacy of systems of monitoring the treatment and care of clients. At Chelmsford Private Hospital in New South Wales the discredited and dangerous 'deep sleep' therapy was used throughout the 1970s despite mechanisms for review and reporting of the institution's operations. The poor standard of care and lack of training programs in some institutions for intellectually disabled persons were also brought to the community's attention. Reports of the indiscriminate use of electroconvulsive therapy (ECT) also highlighted the lack of any system of monitoring the practice and thus of providing accountability to clients and the community at large.

By the 1980s, therefore, those wanting to legislate for accountability in mental health services were at least as much, if not more concerned, with mechanisms for regulating particular treatments and standards of care as they were with the traditional emphasis on regulating custodial care.

These developments provide the context for an exploration of the role of recordkeeping in supporting the accountability mechanisms introduced by the 1986 *Mental Health Act*. I return to elements of this context throughout this paper because changes in the role and quality of recordkeeping are very closely related to changes in the focus of psychiatric services and as a result are more complex than I allowed for at the outset. My research project began with two questions. Firstly, what connection is made between recordkeeping and the accountability issues abounding at the time the Act was drafted, and embodied in it, and how have legislators articulated the value and role of recordkeeping? Secondly, does the practice of clinical recordkeeping in psychiatric services adequately support the legislative requirements? I was initially disappointed to find that the Act and

regulations made under it pay less attention to the keeping of records than any previous mental health legislation. I remain disappointed by my lack of success at extracting a clear expression of the values which those who drafted the legislation attributed to records which may shed light on their nature as foundations of administration and law. However neither of these deficits summarises the relationship between the *Mental Health Act* and recordkeeping. Whilst the letter of the law regarding recordkeeping has shifted in emphasis and on the whole diminished, the spirit of the law — protecting patients' rights — has rendered recordkeeping integral to its purposes.

Since last century lunacy/mental health legislation has always included extensive recordkeeping requirements. Until the 1959 *Mental Health Act*, lengthy schedules have specified not only what records must be kept, when and by whom, but also what form they must take. In 1959, whilst the Act prescribed certain records which had to be created, the forms to be used were set out in regulations. In an environment where judicial aspects of mental health were of primary concern to administrators, these legal documents such as medical certificates, orders and warrants for admission and detention, discharge and boarding out, and journals and registers for recording periodic examinations of patients doubled as records of each patient's clinical history and treatment. No distinction was drawn between documenting an individual's legal status as a patient and documenting their illness or treatment. A tight link therefore existed between documents legally required to be created and the management of patients in mental hospitals. Regulations made in 1962 under the 1959 Act for the first time prescribed forms to be used for keeping a record of a patient's condition that was first and foremost clinical rather than legal in nature.

The 1986 *Mental Health Act* represented a major shift away from using the law as a prime determinant of the management of patients. A decision was taken to reduce the role of the judiciary in admissions procedures by restricting powers of committal to psychiatrists, and to legislate for psychiatric service delivery and the protection of patients' rights.² Earlier legislation was described as featuring a 'paternalistic' approach to the containment of the mentally ill.³ However despite the attention paid to patients' rights in all commentaries on the 1986 Act, the same commentaries pay very little attention to recordkeeping and draw few links between records and the accountability that they saw as integral to the new direction they were setting. In sharp contrast to previous legislation, where the records prescribed served a legal and (in the absence of any other records) clinical purpose, the writers of the position papers and reports upon which the Act (and related intellectual disability services and guardianship administration legislation) is based, categorise recordkeeping as largely administrative. No links are made to either clinical care and treatment

or to ensuring that proper procedures are in place to guard against abuses of the system. The clearest expression of the policy makers' attitude towards records is found in the Victorian Committee on Mental Retardation's report to the Premier on mental retardation legislation (a preliminary report towards the development of the 1986 *Intellectually Disabled Persons Services Act*). The Committee commented that: '(t)here is no question that a good service delivery system requires the maintenance of adequate and relevant records. At the same time, it should be recognised that recordkeeping systems change all the time'. The Committee recommended that legislation should empower the Governor-in-Council to make regulations concerning the keeping of client records and that these regulations should 'prescribe the nature of information to be retained by the organisation, but should not go into excessive detail about the content of forms and records'.⁴ The Victorian Mental Health Division's position paper on mental health legislation agreed that for administrative ease the recordkeeping provisions of the 1959 Act should be simplified by removing them from the Act and using regulations or administrative memoranda. It felt that this could be done 'without reducing the degree of responsibility for proper recordkeeping...It would probably be satisfactory to specify that the Authorised Medical Officer should be responsible for the quality of all records kept in approved or gazetted units'.⁵ The position paper does not discuss what good quality recordkeeping entails nor explain why previous legislation included references to records. No links are drawn to other purposes of the Act.

The result is a piece of legislation with many fewer recordkeeping requirements than previously and with no specifications for the nature or form of those records which are prescribed. In particular, the regulation of involuntary admission and detention, the focus of previous mental health legislation and its documentation requirements, is in 1986 the subject of brief attention. Two documents are necessary for the involuntary admission of a patient; a request and a recommendation prepared and signed by a medical practitioner. The form and content of both are prescribed in 1987 regulations made under the Act. Other records required to be created by psychiatric service institutions are monthly returns to the State's Chief Psychiatrist on the use of restraint, seclusion and non-psychiatric treatment, and a report to the Chief Psychiatrist on the annual medical examination of patients. Other references to documents include that all patients must be provided with a statement of their rights shortly after admission, that the Mental Health Review Board must upon request provide a statement of its reasons for a determination, that Community Visitors must keep a record of all their visits to psychiatric service providers and must report to Parliament, and in turn that the Chief Psychiatrist and Community Visitors are empowered to inspect

any patient record and any record required to be kept by or under the Act.

The 1987 regulations made under the Act include twelve scheduled forms. Four of these relate to the admission process; a form requesting the admission of an involuntary patient, one recommending admission of an involuntary patient, one for recording any restraint used to bring a patient to hospital, and a special warrant issued by a Magistrate to the police to use force necessary to enable a medical practitioner to examine a person who appears to be mentally ill. Of the remainder, five relate to the licensing of premises administering electroconvulsive therapy (a reflection of the level of concern about this practice at the time), one is the form for Community Treatment Orders and two relate to the registration of Community Support Services.

When compared to previous legislation the above summary of the recordkeeping requirements of the 1986 Act suggests that legislators did not primarily see recordkeeping as a means of achieving their accountability related aims. It is not possible to measure to what extent recordkeeping provisions were the victim of ignorance (a purely administrative, procedural matter not linked to the policy and framework established by legislation) and to what extent they were the victim of a bad reputation, having been seen for over a century as an instrument of incarceration, as a component of a custodial, judicial mental health system which legislators wanted to reform. Arguably in either case recordkeepers have some way to go in spiriting an understanding of records as a foundation of democratic accountability and in particular as playing a role in guaranteeing the rights and liberties of members of society.

However despite the poor coverage given to recordkeeping directly by the Act and by the policy statements upon which it is based, in practice administrators and clinicians have created records in order to meet many of the requirements of the letter and spirit of the law. There are several procedural requirements of the Act which are directly supported by the creation of records. For example, the Act requires that a hospital's authorised psychiatrist assesses every involuntary patient within twenty four hours of his or her admission and either confirms the involuntary admission or discharges the patient. Although no records are referred to, the Office of Psychiatric Services' (OPS) procedures establish a form to be used to document this requirement. Similarly, the Act requires that a patient's 'informed consent' is obtained if a course of electroconvulsive therapy is proposed. An 'OPS form' is used to document this consent, or in certain circumstances where electroconvulsive therapy can be administered without informed consent, another form must be used to explain why informed consent was not obtained. Other recordkeeping requirements imposed by the Office of Psychiatric Services in order to

support obligations under the Act relate to monitoring the use of the electroconvulsive therapy machinery and the regular monitoring of patients subject to restraint and seclusion. In total there are thirty-four OPS forms required to be used for administrative reporting and documenting legal obligations.⁶

Further evidence of the importance of recordkeeping in the provision of psychiatric services is provided by the Office of Psychiatric Services' Medical Records Adviser, Marie Matthews, who reports that unlike five years ago, trained medical records administrators are now employed in most institutions and that the level of resourcing given to them is usually adequate. Once again this is not a direct result of the 1986 Act, but, Ms Matthews believes, is partly a result of the climate of civil liberties concerns reflected in the Act and the resultant need to ensure that there is recorded evidence of the interactions between clients and service providers. Professional medical records administration is therefore seen as an insurance policy for the State, and for medical and nursing staff, as much as for clients. Both internal and external scrutiny of various institutions and the cases of particular patients in recent years have further heightened the awareness of accountability.⁷

It seems, therefore, that although it is not directly driven by legislation, recordkeeping is seen as fundamental to providing for accountability in psychiatric services. While the Act says less about records than previously, the policies and procedures it embodies depend more on records than before. Additionally a development of the 1986 Act which has had crucial consequences for recordkeeping are the review mechanisms established by it which, in scrutinising the activities and decisions of service providers, have often begun by scrutinising their records. The two major review mechanisms established by the Act are the Mental Health Review Board and the Community Visitors Program.

The main functions of the Mental Health Review Board are to review all involuntary admissions between four and six weeks after admission (the cases of involuntary patients discharged prior to this are not reviewed) and to hear appeals, which may be lodged at any time, by involuntary patients against their detention. In either case the Board can overturn an existing decision and discharge a patient.

At a hearing the Board hears the views of treating psychiatrists and on occasion nurses, social workers and other health professionals. The patient may address the Board and may be represented by a lawyer or assisted by a friend or relative. At the beginning of a hearing the patient's clinical file is placed before the Board and the patient is in most cases also allowed access to his or her file.⁸ The Board has not, in its 1991 *Annual Report* (the only one which I examined), commented upon whether this scrutiny of patient files by an independent tribunal

and by clients has led to better or worse recordkeeping. Marie Matthews believes it has contributed to the provision of proper medical records administration in institutions. However at a more fundamental level the Board has noted the concerns of medical and nursing staff that access by patients to all information on their files may sometimes not be in the patient's best interests or may make staff the subject of reprisals.⁹ I have no evidence of whether or not these concerns have resulted in less complete, less explicit notetaking.

The Board has paid particular attention to the legal requirements surrounding involuntary admission. In the twelve months to June 1991 the Board found thirty-five cases of invalid involuntary admission. This represents slightly over 1% of all hearings. It has found about the same proportion of invalid admissions in previous years.¹⁰ Some causes of invalidity have been the absence of a signature on a psychiatrist's confirmation of admission report (thus it could not be shown that a psychiatrist had written it), the absence of an admitting document required by legislation and the use of out-of-date forms rather than those required by current regulations.¹¹ I have no statistics on the ultimate outcome of all of these cases; the Mental Health Review Board reports that in some cases the institution has immediately (re)admitted the person validly whilst in others the person has been free to leave.¹²

The fact that five years into the operation of the Mental Health Review Board the incidence of invalid involuntary admission has not declined is in conflict with the prevailing view that understanding of accountability issues and of the importance of recordkeeping has heightened recently. An explanation of this discrepancy was offered by the legal adviser of the Office of Psychiatric Services who reported that (in stark contrast to fifty years ago) the 'legal records' required by law or by the Office of Psychiatric Services are not relevant to the daily work of patient care and treatment. A different type of record is kept for the 'real work', and although clinical notes and legal documents are filed together on each patient's file, more care may be taken with the former. In light of the confidence which seems to prevail that unjust and inappropriate involuntary admissions are extremely rare and that accountability lies in proper care and treatment, one view is that this emphasis is vastly preferable to the reverse, since it is in keeping with the spirit of the law even if it is less so with the letter. Although it is critical of some admission practices and has found some cases of unjustified involuntary admission, the Board does not report that any of the thirty-five cases of invalid admission in 1990-91 has constituted a conspiracy or a deliberate breach of the patient's rights. (On the contrary, in some cases it has been quick to point out that it sees nothing sinister about the illegality.) However the Board's findings indicate the scope for abuses of the involuntary admissions procedure.

Unfortunately, the Mental Health Review Board will no longer provide this scrutiny of admissions' legality. In August 1991 the Board heard an appeal in which the patient's lawyer argued that the involuntary admission had been invalid because the medical practitioner recommending admission had not documented his or her opinion that all the criteria necessary for involuntary admission were met in the patient's case. In similar cases previously the Board had found that the person was not legally an involuntary patient. A recent change in personnel at the Board, however, led to a different outcome, and a Supreme Court judgement delivered in March 1992 supported the Board's approach. The Court ruled that it is not the Board's role to assess the validity of an involuntary admission but rather its powers relate to determining whether ongoing detention is justified. If a patient is before the Board and is not a voluntary or security patient, then he or she is an involuntary patient regardless of any defects in their admission documentation:

Dr Hanscombe [counsel for the patient] submitted that the Board could not perform its function without being first satisfied that XY had legally been deprived of his liberty. She emphasised the grave consequences of the denial of this fundamental right.

While this submission is treated with great respect, the liberty of XY is hardly neglected by the Board entertaining the appeal. If a patient has been illegally admitted due to technical procedural defects but is nevertheless in need of care and treatment because the criteria for his or her admission have been fully applicable, the patient is not disadvantaged by technical illegality. If on the other hand, the patient ought not, on any basis, have been admitted, the avenue to the Board, which has the power to conduct an appeal and a review at the same time (and direct a discharge), will almost certainly procure a more speedy restoration of liberty than any other.¹³

The Court's judgement does not render the admission documents worthless, but it does remove the most powerful mechanism for scrutinising legally required recordkeeping, conceivably reducing the likelihood that a breach of human rights, such as certification without psychiatric examination, will be brought to light.

The second major 'watchdog' established by the Act is the Community Visitors Program. Although previous legislation had provided for 'Official Visitors' with powers of inspection and reporting, the 1986 Act gave Community Visitors more extensive responsibilities and inspection powers than previously, and gave clients a right to speak with Community Visitors at any time. As well as legislative changes, the coordination of the program by the Office of the Public Advocate has made Community Visitors far more influential than their earlier counterparts. Community Visitors have not, in annual reports to Parliament, made particular comments about the adequacy of recordkeeping (other than reporting that they have examined ECT registers and found them to be up-to-date), yet their

approach to the inquiries they make depends in part on records. A large part of Community Visitors' work recorded in annual reports relates to concerns of or about individual clients. If a client has a complaint about care or treatment, the client's file may be examined to determine how staff have managed the case. Clinical notes become evidence of what treatments have been used, what 'incidents' have taken place and what level of care and monitoring staff have given.

I spoke to one Community Visitor, Mrs Daisy Bennett. She has used files to ascertain whether patients' claims about treatments and care they have received are correct, to investigate whether patients who have died in institutions have received appropriate care and medical treatment prior to their death, and whether a long term patient's psychiatric treatment is regularly assessed. Mrs Bennett, formerly a psychiatric nurse herself, feels that as a result of this scrutiny staff are now more aware of the need to protect themselves by taking more care with clinical notetaking. Much more detailed records of patient management are now made partly as a necessary facilitator of patient care, but also because a patient's file is now 'almost a legal document'. When questions are raised by Community Visitors or others, institutions must be able to use their records to account for their actions. Despite this overall improvement in recordkeeping Mrs Bennett felt that in many cases still not enough information is collected and that although notetaking has improved, the use of information collected lags behind. She cited an instance where there was a note on file about a patient's financial circumstances that was relevant to a decision about treatment but staff had not looked for the information at the time.

A similar use of records to that reported by Mrs Bennett has been made in two reports recently presented to the Minister for Health. The Task Force appointed to investigate Aradale Psychiatric Hospital and Residential Institution at Ararat reported to the Minister in November 1991. Although sparked by specific allegations of fraud, theft, patient abuse and unprofessional practices, the Task Force also inquired generally into the provision of services at Aradale. The Task Force's report makes some references to recordkeeping but of greater interest is the use which the investigation made of records.

The report begins by outlining the investigative procedure used:

The investigations commenced on Monday 20 May 1991. The Task Force attended at Aradale Psychiatric Hospital and Residential Institution and secured clinical, financial and personnel records. The investigation continued on site for some 4 months, concluding in late September 1991. . . . In the course of investigating these serious allegations the Task Force inspected numerous documents and interviewed staff, patients and residents at Aradale as well as members of the Community.¹⁴

Both in investigating specific incidents and in their general assessment of Aradale, the Task Force have expected records to be evidence of what happened, and wherever they have found a lack of records, or 'fictional' records, they have suggested a lack of accountability, a lack of proper patient care or in some cases a criminal act.

For example, the Task Force investigated the practice of 'pooling' money from patients' trust accounts into 'Ward Funds' which were accessed by staff rather than patients. All cash books, receipts and other supporting documentation kept in wards were examined and compared with Trust Office records. An examination of receipts raised concerns about the uses to which money was put, for example the purchase of pantyhose and nurserywear on an all male ward! Also of concern was the attitude of staff, including Trust Office staff, towards the keeping of receipts. The Task Force was critical of the Trust Office's instruction to 'try and keep as many receipts as you can' and of the widespread use of a 'two sets of books system', one of which was supposed to account for money spent but did not record individual transactions, and another comprising 'backs of envelopes, vouchers and/or scraps of paper' which did record some transactions but which could not be reconciled either with the other set of books or with money actually spent. When the Task Force did their own accounting they found that for the 1990 calendar year \$109,443, or 40% of 'pooled' funds could not be accounted for.¹⁵

A similar exercise was undertaken using meal books, menus and kitchen stock records and revealed that between 20% and 50% of food purchased was not reaching patients. Poor stock control prevented the Task Force from being more precise, but they nevertheless concluded that 'large-scale systematic pilfering' was operating in Aradale.¹⁶

In addition to these more conventional areas of audit the Task Force examined records to assess the quality and consistency of policies and procedures, the accountability of staff to nursing management, the quality of communication between staff, the attitudes of staff towards their patients and the appropriateness of the institution's responses to particular incidents. Never articulated but clearly assumed is an understanding of the essentiality of documentation in providing a psychiatric service and an expectation that an institution should be able to provide detailed and internally consistent written records as evidence of proper provision of that service.

A second report, *Audit of Standards of Treatment and Care in Psychiatric Hospitals in the State of Victoria*, was released in March 1992. The audit was to investigate 'the clinical standards and accountability in all State Psychiatric Hospitals', including 'the treatment of patients within accepted standards, the adherence to the Statutory requirements of the *Mental Health Act* (1986) and the

attention given to ensuring patients' rights are protected'.¹⁷ The audit encompassed nineteen in-patient psychiatric services around Victoria. Part of the audit was a document audit. 25% of all current patient files were examined, plus files of patients recently discharged, patients receiving electroconvulsive therapy, patients placed in seclusion and patients who had died in hospital. Additionally, minutes of meetings, policy and procedure manuals and other records were examined. The audit also involved interviewing a large number of staff and patients and inspecting the facilities of all wards. The approach in itself demonstrates the importance placed on recordkeeping in supporting accountability, and the audit's findings draw the same connection. There are numerous examples of the audit team linking their assessment of the quality of documentation to the quality of service.

The audit team has documented its understanding of the significance of the clinical file as follows:

The clinical file serves as a store of knowledge about a patient, a record of patient care that is planned, a record of treatment and care that is delivered, a record of communication between service providers, patients and their families or advocates, a vehicle for communication between staff and a legal document.¹⁸

This six-part definition of the purpose of documenting patient care mirrors the use which the audit team has made of records in their audit.

Firstly they have used files to assess whether enough information is collected about patients to facilitate proper case management. For example they have examined admission reports to see if they document all relevant aspects of a patient's background and to see whether pre-existing medical problems are identified.¹⁹ Thus they have viewed records as information stores.

They have also expected case files to provide evidence of the planning and delivery of care and treatment, and have used them as a basis for assessing the adequacy of case management. For example, the team assessed patient nursing care plans to determine whether strategies have been developed and implemented to assist patients to overcome particular problems such as aggression towards other patients or deficiencies in particular 'living skills'.²⁰ If such 'rehabilitation programs' are not recorded on file the audit team has assumed they are not extant and has been accordingly critical of services. Treatment is assumed to be directly linked to documenting treatment.

The audit team has also tested the quality of communication between staff and patients. For example they have compared drug treatment records on patients' files with those patients' understanding of their medication.²¹

Clinical records were also assessed for their effectiveness as a means of communication between staff. The audit found that some key information was quickly buried beneath other papers, that some clinical service providers did not contribute in writing to case planning, and that instructions from medical staff to nursing staff were often not detailed enough.²² The audit team saw case files as the prime form of communication between staff. Again, if there is no written evidence that information has been communicated, the audit team has assumed that it has not been.

Finally the audit team monitored the effectiveness of records in meeting the requirements of the *Mental Health Act*. It found a small number of instances where the law had not been fulfilled, or where it could not find evidence to prove that it had been. Such instances related to the reporting of the use of seclusion, the lack of evidence that annual examinations had been carried out, and the lack of evidence that patients had been informed of their rights.²³ With the exception of the last breach of the law, which was widespread, the audit team was quick to point out that the instances it reported represented a very small number of all files examined and that they '(did) not involve a significant neglect of the patient's rights or needs'.²⁴

The audit team seems to concur with other commentators in its view that even where legal recordkeeping requirements are not met, these omissions do not constitute a serious breach of patient rights or a breakdown in accountability mechanisms. Inadequate day-to-day recordkeeping is, however, of far greater concern as these records are seen as vital to accounting for all aspects of the provision of psychiatric services.

Inherent in the 'clinical audit' approach to assessing psychiatric services is an understanding that documents are evidence of transactions, of interaction. Whilst those who have been afforded the task of ensuring that the interests of clients are fully promoted and their rights protected have seldom commented explicitly on the value of recordkeeping, its significance to them is powerfully displayed by their expectation of it: that it will account for what happened, that it will explain the relationship between client and service provider and hence between client and State. Concerns about ensuring that this relationship is proper have directly caused increased attention to be paid to recordkeeping, both by those who create documents and by those who manage them. However legislation itself has not directly given records and recordkeeping such force. Rather, accountability mechanisms such as the Mental Health Review Board, Community Visitors Program and the 'audit' style of service appraisal have, unlike previous regulatory mechanisms, provided extensive scrutiny of records, and documentation has improved as it has been looked at more. Documentation has also improved as it has been relied on more;

not only as more evidence of proper case management has been needed, but also as options and expectations for patient care and treatment have increased with a resultant need for a better supply of information. As the role of psychiatric services and institutions has expanded, the role of recordkeeping has also expanded to meet information needs and, in the same documentation process, to facilitate accountability.

ENDNOTES

1. A summary of these concerns can be found in S. Tait, 'The Victorian Health Department's Perspective of Mental Health Legislation', in *The Patient, the Law and the Professional: Proceedings of the 11th Annual Congress of the Australian and New Zealand Association of Psychiatry, Psychology and the Law*, Melbourne, 1990, pp.115-116.
2. *Report of the Consultative Council on Review of Mental Health Legislation*, December 1981, p.53.
3. *The Mental Health Act and Other Resources: A Practical Guide*, Office of Psychiatric Services, 1992, p.14.
4. *Report of the Committee on a Legislative Framework for Services to Intellectually Disabled Persons*, Victorian Health Department, 1984, pp. 205-206.
5. *Mental Health Legislation. A Position Paper*, Mental Health Division, Health Commission of Victoria, 1980, p.77.
6. The use of OPS forms is outlined in *The Mental Health Act and Other Resources*, pp.120-124.
7. Other factors which Ms Matthews identified as having improved standards of recordkeeping in recent years are the 'mainstreaming' of psychiatric services within other public health services and the resultant application of normal medical records practices and standards, and the increased professionalism of nursing staff who are the main contributors to patient records.
8. *The Mental Health Act and Other Resources*, p. 54.
9. Mental Health Review Board, *Annual Report*, 1991, p.14.
10. *Ibid*, pp.40-41
11. *Ibid*, pp.33-35.
12. *Ibid*, p.33.
13. Supreme Court of Victoria, Appeal Division, *Report of Judgement in the Matter of a Special Case Stated Pursuant to Section 118 of the Mental Health Act 1986, No.12501 of 1991*. Quote is taken from the judgement of Judge Marks, p.14.
14. *The Investigative Task Force's Findings on the Aradale Psychiatric Hospital and Residential Institution*, Office of Psychiatric Services, 1991, p.6.
15. *Ibid*, pp.39-47.
16. *Ibid*, pp.39-47.
17. *Audit of Standards of Treatment and Care in Psychiatric Hospitals in the State of Victoria*, Office of Psychiatric Services, 1992, p.(i).
18. *Ibid*, p.78.
19. *Ibid*, pp.26-30.
20. *Ibid*, pp.16-18, p.37.
21. *Ibid*, p.63.
22. *Ibid*, p.64, p.30.
23. *Ibid*, p.7, p.26.
24. *Ibid*, p.26.