

Mental Health
Complaints
Commissioner

2014-15 Annual Report





21 August 2015

The Honourable Martin Foley, MP
Minister for Mental Health
Level 22, 50 Lonsdale Street
Melbourne 3000

Dear Minister,

I am pleased to provide you with the annual report of the Mental Health Complaints Commissioner for the financial year 2014–15.

As required under s 268 of the Victorian *Mental Health Act 2014* (the Act), the report describes our activities for the year, including the number of complaints made to the Commissioner, the outcomes of such complaints, and our education activities.

I trust our first annual report will help inform the Parliament, consumers, families, carers, mental health services and the wider Victorian community about our key safeguarding, oversight and service improvement role under the Act.

Yours sincerely

Lynne Coulson Barr
Mental Health Complaints Commissioner



Tel: 1800 246 054 | Fax: (03) 9949 1506 | www.mhcc.vic.gov.au | help@mhcc.vic.gov.au | Level 26, 570 Bourke Street, Melbourne, VIC 3000

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Level 26, 570 Bourke Street
Melbourne, Victoria 3000
Australia
Phone: 1800 246 054
Fax: (03) 9949 1506
Complaints: help@mhcc.vic.gov.au
Other: info@mhcc.vic.gov.au

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Message from the Commissioner



I have the privilege of being appointed as Victoria's first Mental Health Complaints Commissioner and to report on the achievements and activities of our office in its first year of operation. I commenced my role on 28 April 2014, through appointment by the Governor in Council. Just nine weeks later, on 1 July 2014, the office of the Mental Health Complaints Commissioner (MHCC) commenced operation under the new *Mental Health Act 2014 (the Act)*.

The Mental Health Complaints Commissioner is a key component of the increased safeguards, oversight and service improvement provisions introduced in the new Act. The office provides an independent, specialist avenue for progressing complaints about public mental health services and promoting service improvements.

The right to make a complaint is essential for protecting all other rights, providing a critical safeguard for preventing and addressing alleged harms and rights breaches. Effective complaints processes are also essential for service improvement. They provide a window into people's experience and give services the opportunity to respond in ways that improve outcomes for the person involved and for others.

For people experiencing mental illness, families and carers, their experience with mental health services can be associated with severe distress, trauma and, at times, the loss of liberty. People have told us how difficult it is to speak up about their concerns in the face of these challenges, when already dealing with the difficulties inherent in mental illness and the social stigma it still carries.

As you will read, our work over the first year of operation has focused on mitigating these barriers and ensuring people feel supported to raise their concerns in the midst of these challenges. We have been promoting our new role, building confidence in our approach, encouraging new ways of thinking about and responding to complaints, and starting new conversations between services and consumers, families and carers. In all our work, we have focused on our role in safeguarding rights and promoting service improvements, and have worked to resolve complaints in ways that support people's recovery.

In so doing, we have given close attention to the Act's mental health principles, working with consumers, families, carers and services to achieve outcomes that respond to consumers' individual needs, supporting them to make or participate in decisions related to their treatment, and enabling carers to be involved in decisions whenever possible.

This commitment has also required new conversations with services about complaints. I have met with every public mental health service to discuss our role and approach, and to learn of their experience delivering services and responding to complaints under the new Act. My team and I have visited 123 service sites – including all inpatient units and the majority of residential programs in the community – to gain an appreciation of the context of each service and to learn about their challenges and initiatives in supporting people's recovery. I greatly appreciated the positive engagement shown by services in hosting these visits, and the open discussions we've had with senior management, clinicians, staff, consumers, families and carers about their experiences.

The following report outlines the foundational work of our establishment team and the pivotal community consultations that informed our approach. It details our activities and achievements in safeguarding rights, resolving complaints, contributing to service improvement, building knowledge, skills and confidence through education and engagement, and reviewing services' complaint data as part of our oversight role.

This work has seen many successes: We've received almost 1,500 enquiries and complaints, close to 7,000 calls on our 1800 phone number and over 3,000 written communications. This level of engagement far exceeds estimated demand, and demonstrates the value of having an independent, specialist complaints body to respond to the unique needs of people accessing mental health services.

We have also been heartened by the positive responses we've received from services and the outcomes these responses have delivered. As required by the Act, public mental health services have begun to provide their complaints data to us. Through our resolutions work, we've seen and facilitated a range of policy and practice changes that have and will continue to benefit people who rely on public mental health services.

Not surprisingly, our work has presented a number of challenges. Demand has severely tested our resources, and we have worked diligently to evolve our practice so we are available and responsive to this demand. Our capacity to capture and report on our activities has been limited by our electronic database – the case management system (or CMS) provided on establishment. We look forward to implementing our customised CMS in 2015-16 and providing improved data capture and analysis in future reports. Likewise, our first collection of complaint reports from services has revealed the need for improved guidance and support for services about the data to be collected, and the development of a common reporting tool that is supported by the sector and can be used in conjunction with existing systems.

More broadly, complaint data points to the need for the sector to consider further service and practice improvements to ensure the mental health principles and rights enshrined in the Act apply to, and are able to be experienced by, all consumers. Reliable complaint data will assist in identifying underlying systemic issues impacting on service provision, and we look forward to bringing our independent voice and evidence base to this work.

We are also working to better understand the demand for our service, improve our resolution processes and communication with all parties, and work more agilely to achieve optimal outcomes for our efforts.

The successes and challenges of our office are collective successes and challenges, and I thank the many people who continue to drive and support our work. I thank the Hon Martin Foley MP, Minister for Mental Health, and the former Minister for Mental Health, the Hon Mary Wooldridge MP, for their strong support and commitment to the role of our office, and the Department of Health and Human Services (DHHS) for their significant contributions to establishing our office and their ongoing support and shared commitment to our common goals.

I would also like to acknowledge the many people working within public mental health services and in consumer and carer organisations. In focusing on complaints, it is important to acknowledge that service staff work in challenging environments and circumstances, and I have seen in my visits how people working in services strive to make a positive difference, working with consumers, families and carers and advocacy organisations in this quest.

I give special thanks to the MHCC staff for the passion, energy and care they bring to their work each day. I also wish to thank our establishment team and the many people and organisations that generously gave their time and insights to help us build the strong foundations now in place. We have benefited from the warm welcome and generous support provided by the Health Services Commissioner in the co-location of our offices and establishing strong and collaborative working relationships. I also acknowledge the ongoing support of consumer and carer organisations, the many DHHS officers who assist our operations, the Chief Psychiatrist, Clinical and Executive Directors of services, our colleagues in other statutory bodies and the many committed community members who continue to support us as we build on these foundations.

This collective effort is testament to the relevance of the key messages we developed with consumers, families and carers: 'Speak up. Your experience matters' and 'Speaking up improves services for everyone'. We look forward to continuing to work with you to make this difference.

Lynne Coulson Barr

A snapshot of achievements

The Mental Health Complaints Commissioner is a key part of the safeguards, oversight and service improvement provisions established under the *Mental Health Act 2014*, and we bring this focus to all our work. This snapshot highlights our key activities and achievements in our first year of operation.

Establishing the office and our approach

- Our establishment team developed our model following extensive consultations with over 400 individuals and 80 groups.
- Our approach (including principles, logo and key messages) was also developed through consultation with consumers, families, carers and services.
- We opened on 1 July 2014, with most of our functional systems, staffing and communication platforms in place – just over nine weeks after the Commissioner commenced in her role.

Safeguarding rights and upholding the mental health principles

- We developed and promoted key messages to address potential barriers to making a complaint and promote the right to make a complaint: 'Speak up. Your experience matters' and 'Speaking up improves services for everyone'.
- We reviewed complaints for issues relating to risk, safety and rights under the Act, and escalated as needed for preventative or remedial action.
- We identified where the existing policies and practices of services required review to ensure consistency with rights under the Act, such as the right to communicate and the right to the least restrictive treatment.
- We introduced a 'rights-based' approach to complaints through the first phase of our education and engagement activities.

Building awareness and capacity through education and engagement

- We undertook 135 education and engagement activities with almost 11,000 participants, including 50 presentations by the Commissioner to over 3,000 people.
- In these sessions, we provided information about our role and the importance of speaking up and introduced the 'Four A's' of complaint resolution: Acknowledgement, Answers, Actions and Apology.
- Our engagement activities included participation in 57 stakeholder meetings, events, forums and conferences, and six community events.
- We met with every public mental health service in Victoria, visiting 123 service sites and facilities, and talking with 479 staff and 101 consumers and carers.
- We distributed more than 25,000 information and promotional products highlighting our role and key messages about complaints to consumers, carers, families, other community members and services.
- We promoted our role and approach to complaints through social media, attracting more than 2,200 followers on Facebook and almost 300 followers on Twitter.

A NOTE ABOUT OUR LANGUAGE

Guided by input from people with lived experience, families, carers and services, we aim to use inclusive and person centred language. We appreciate the diversity of views and preferences on terms such as consumers and patients. In most cases, throughout this publication we use the terms as they appear in the *Mental Health Act 2014*. We also reference families and carers, and use the term 'services' to refer to public mental health service providers.

Education and Engagement activities undertaken

135 11000

activities

people reached

“I hope that the Mental Health Complaints Commissioner will improve people’s experiences of making complaints.”

– Consumer

How we are reaching people

in person engagements			additional outreach		
					
123 sites visited we reached every service in Victoria	50 presentations delivered	3000 people reached	25K info & promo products promoting our role & key messages	2200 facebook followers	300 Twitter followers

We responded to

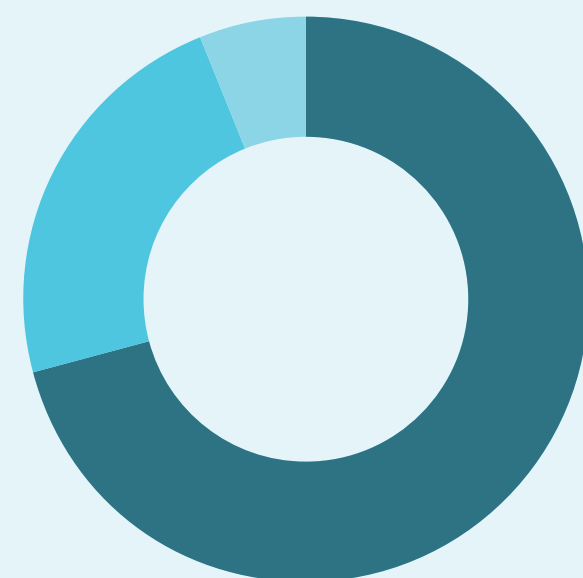
1456

enquiries and complaints

We received

6931

calls to 1800 246 054



71%

of all enquiries and complaints were raised by consumers

23%

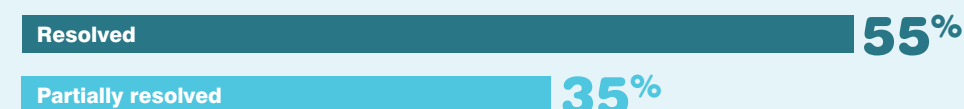
of all enquiries and complaints were raised carers and family members

6% other

We promote early resolution where possible



Improved outcomes on “in-scope” complaints



Providing new avenues and approaches to resolving complaints

- We responded to 1,456 enquiries and complaints, received by phone, email, on-line form, fax and Facebook messages and in person.
- Over 1,000 enquiries and complaints (71 per cent) were from consumers, and 23 per cent were from carers and family members.
- We received 6,931 calls to our 1800 number and responded to 3,376 pieces of correspondence relating to enquiries and complaints.
- We promoted early resolution of concerns wherever possible, with 38 per cent of enquiries and complaints closed within one week, and a further 26 per cent closed within one month.
- We engaged directly with clinical directors, service managers and treating teams to resolve complaints in ways that recognise people’s rights, support recovery and improve services.
- We achieved improved outcomes for individuals or agreements on actions to address issues in 55 per cent of all of ‘in-scope’ complaints, with partial resolution achieved for a further 35 per cent.

Increasing knowledge and oversight through complaint reporting by services

- We completed an initial scoping project with services to inform the development of effective complaint reporting arrangements.
- We met with every designated public mental health service and the majority of mental health community support services to discuss the objectives and requirements of complaint reporting under the Act.
- All services provided their data in our first collection period.

Promoting service and systemic improvements

- We made 7 formal recommendations to services to review specific policies and practices in light of issues raised in complaints, and confirmed service improvement actions initiated by services in over 10 matters.
- We made recommendations to the Department of Health and Human Services to review policy and practice issues relating to access to mobile phones and communication devices in acute inpatient units, fees charged in Secure Extended Care Units and the use of restrictive interventions in emergency departments.
- We participated in consultations and made a submission to the National Disability Insurance Scheme quality and safeguards framework.
- We contributed to a range of quality and safety initiatives, providing input into the Australian Commission on Safety and Quality in Health Care (ACSQHC) projects on medication safety and consumer engagement and shared decision making.
- We provided submissions to the 2015 Review of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the Victorian Equal Opportunity and Human Rights Commission’s annual Charter report.

Learning and growing our capability

- We have built a skilled and diverse team, with staff participating in a broad range of training and education activities, including the accreditation of resolution officers under the National Mediator Accreditation System.
- A customised case management system has been developed to support our complaints resolution work and to provide enhanced data reporting in 2015-16.
- We have developed strategic directions to guide our work over the next four years, and will continue to consult to ensure our strategies respond to the issues and priorities identified by consumers, families, carers, services and other stakeholders.

“

I called the MHCC to make a complaint and was impressed with their response. The person I spoke to listened to me and talked to me about what we could do. He was thorough and productive and helped me with my case. He also called me back a while later to check on how things were going; I really appreciated that, and wasn’t expecting it. It feels like the MHCC has made a great start.”

– Consumer

01

Background and legislative mandate

“

There are varying standards of responsiveness to complaints.”

– Carer focus groups, Mental Health Complaints Review Project 2009

Our context: A new Mental Health Act for Victoria

The Mental Health Complaints Commissioner (MHCC) is an independent, specialist complaints body established under the Victorian *Mental Health Act 2014* (the Act). The Act was the outcome of an extensive legislative reform process, which sought to:

- reflect contemporary mental health policy and practice
- align with the *Charter of Human Rights and Responsibilities Act 2006*, the United Nations (UN) Convention on the Rights of Persons with Disabilities and the UN Convention on the Rights of the Child
- enshrine the principles of presumption of capacity and supported decision making.

The Act aims to protect the rights and dignity of people experiencing mental illness, and place them at the centre of their treatment and care. It introduces a set of mental health principles to which services must have regard when providing mental health services, including promoting the least restrictive treatment, supporting people to make or participate in decisions about their assessment, treatment and recovery, and recognising the role of carers. These principles must also be upheld by any person performing any duty or function under the Act, including the MHCC.

The Act also introduces a number of new initiatives and protections aimed at promoting and supporting recovery-oriented practice and facilitating strong communication between mental health professionals and consumers, families and carers. These include:

- establishing a supported decision-making model to enable people to make or participate in decisions about their assessment, treatment and recovery and have their views and preferences considered and respected
- promoting voluntary treatment wherever possible, and minimising the duration of compulsory treatment
- establishing a comprehensive suite of safeguards, oversights and service improvement mechanisms to ensure rights are protected and the mental health principles are upheld.

The Mental Health Complaints Commissioner is a key component of these mechanisms.

Why create an independent complaint body?

The MHCC was established in response to community concerns about existing complaint processes raised during the comprehensive consultation and legislative review that preceded the Act.

People reported that complaint pathways could be complex and difficult to navigate, and that responses to complaints had not been timely or responsive to the needs of people with mental illness. Also of concern was the absence of any statutory mechanisms to ensure complaints led to improvements in the safety and quality of mental health services.

The Act established the MHCC as an independent entity to provide an ‘accessible, supportive and timely complaints mechanism that will be responsive to the needs of people with mental illness.’¹

¹ Mental Health Bill, Second Reading Speech 20/2/2014

“

There is a lack of transparency of the complaints system.”

– Carer focus groups, Mental Health Complaints Review Project 2009

Our functions

The Act gives the Commissioner the following key functions:

- to accept, assess, manage and investigate complaints relating to public mental health services
- to attempt to resolve complaints in a timely manner using formal and informal dispute resolution (including conciliation) as appropriate
- to provide advice on any matter relating to a complaint
- to make the procedure for making complaints in relation to services available and accessible, including publishing material about the complaint procedure
- to provide information, education and advice to services about their responsibilities in managing complaints
- to help consumers and people acting on behalf of, or in the genuine interest of, consumers to resolve complaints directly with services, either before or after the Commissioner accepts the complaint
- to help services improve policies and procedures to resolve complaints
- to identify, analyse and review quality, safety and other issues arising out of complaints and make recommendations for improvements to services, the Chief Psychiatrist, the Secretary and the Minister
- investigate and report on any matter relating to services at the request of the Minister.

The MHCC has broad powers to deal with complaints in relation to designated mental health services (as set out in the Mental Health Regulations 2014) and publicly-funded mental health community support services.

To strengthen oversight, the Act also introduces the requirement for all public mental services to provide a biannual report to the MHCC detailing the number of complaints they have received and the outcomes of those complaints.

PUBLIC MENTAL HEALTH SERVICES MEANS:

designated mental health services

A designated mental health service is a health service that may provide compulsory assessment and treatment to people under the Act. These services also provide voluntary treatment and include hospital based services, community residential and area mental health services, specialist and forensic services.

publicly-funded mental health community support services

These are community support services for people with a mental illness that are provided by non-government organisations. These services were created through reforms in 2014 to the services formerly known as psychiatric disability rehabilitation and support services (PDRSS).

02

Establishing the office and our approach



OUR LOGO

The development of the Mental Health Complaints Commissioner's logo has been created in close collaboration with consumers, families and carers.

Consumer groups participated in two workshops to help develop a logo that represented the ambitions of the new organisation and the mission it had to make a difference to the mental health system.

For many people, the tree is a symbol of growth, protection and recovery. The speech bubble leaves represent the voices of people living with mental illness, families, carers and services. They emphasise the importance of communication in assessment, treatment and care, and throughout the complaints' process.

Developing our model and approach

To ensure our approaches reflected the mental health reform objectives, our establishment team consulted extensively with community members living with mental illness, families, carers, peak organisations, services and stakeholders.

The team met with approximately 80 groups representing consumers, carers, services and complaint agencies, including 26 groups in regional areas. These groups are listed in **Appendix 1**. Over 400 individuals were involved in these discussions, and the establishment team sought to understand their perspectives on:

- what 'accessible, supportive and responsive' means in practice
- how consumers, families, carers and services view complaint processes and what makes these processes effective
- what consumers, families, carers and services wanted a new mental health complaint body to do.

Across these consultations, participants demonstrated strong support for a complaint body that:

- is responsive, supportive, flexible and accessible, and enables people to speak directly to one officer and receive assistance
- is staffed by people with a diversity of experience and skills (for example, experience with complaints, lived experience of mental illness, experience with the service system, experience in advocating, investigating and protecting rights)
- helps people resolve their complaints in a timely manner and directly with services whenever possible
- takes an authoritative but consultative approach to complaints and helps services deal with complaints effectively themselves
- takes a proactive approach to complaints, identifying where people may be at risk or need assistance and progressing matters where services may not be responsive
- has a monitoring and safeguarding role and uses its powers when required
- is committed to using individual and collective experiences to drive system-wide improvements, for the benefit of all.

This invaluable input can be seen in the principles and approach we adopted, our logo and branding, and our organisational structure. Most importantly, it is reflected in the way we work.

Opening the office

The MHCC commenced operation on the first day of the new Act, 1 July 2014.

In the nine-week period before opening, the establishment team recruited and trained staff, put systems and processes in place so the office was ready to receive enquiries and complaints, developed a basic website and produced and distributed information and promotional materials.

The office was officially opened by the then Minister for Mental Health, the Hon Mary Wooldridge MP on 12 August 2014 at a welcome event attended by representatives from many of the consumer and carer groups, services and organisations that supported the establishment phase.

TIMELINE

JUNE 2013 — OCTOBER 2014

Fit out for the MHCC's new office

JULY 2013 — JUNE 2014

Consultations about the roles and responsibilities of the MHCC with over 400 people and over 80 groups

NOVEMBER 2013 — FEBRUARY 2014

Logo and brand identity design developed in two workshops with consumer representatives

26 MARCH 2014

Parliament passed the Mental Health Bill 2014

APRIL 2014 — JUNE 2014

Key messages tested through an online survey

8 APRIL 2014

The Bill received Royal Assent and proclaimed as the *Mental Health Act 2014*

15 APRIL 2014

Victoria's first Mental Health Complaints Commissioner Lynne Coulson Barr appointed

28 APRIL 2014

Commissioner commences role

MAY 2014 — JUNE 2014

Staff recruited into key roles

Key messages, logo, brand identity and principles finalised in consultation with consumers, families and carers

Website and social media presence established

Key infrastructure installed and an interim complaints' management system established

Staff inducted and trained

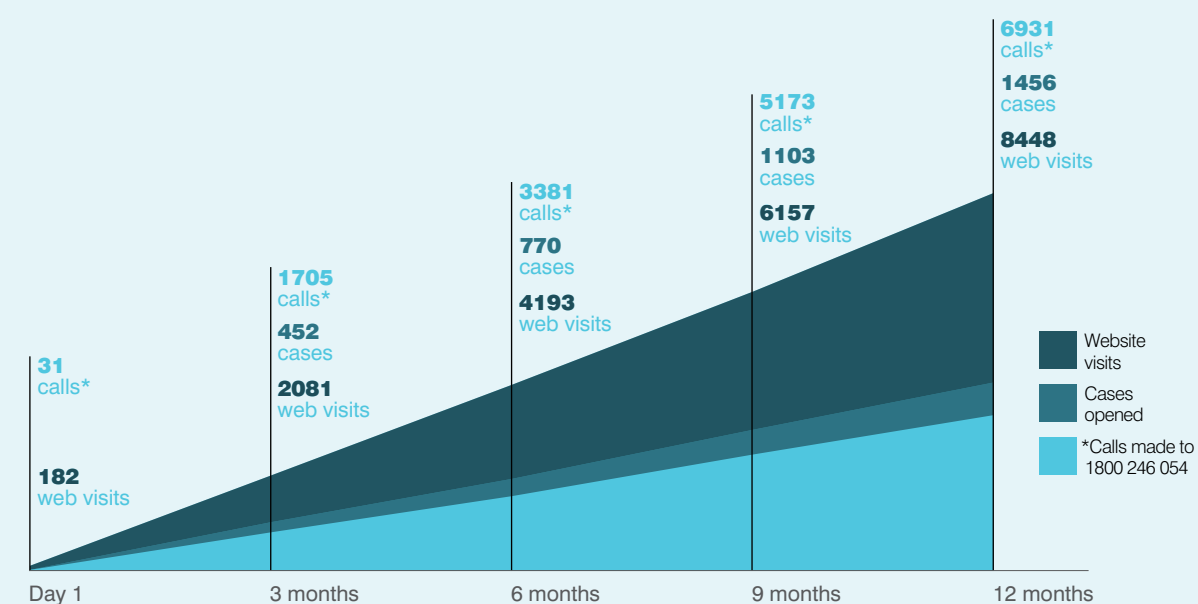
1 JULY 2014

The Act commences and the MHCC officially opens

30 JUNE 2015

The first full year of operation ends

CUMULATIVE SNAPSHOT



- safeguard the rights and dignity of individuals, families and carers
- resolve complaints in ways that support people's recovery and improve services
- support services to develop effective complaint resolution processes
- promote improvements in the mental health system and people's experiences of services.

Our principles have been developed to reflect the objectives of the Act and the themes from the consultations with consumers, families, carers and services.

We understand that being accessible means different things for different people. We are responsive and flexible, and adapt our approaches to people's individual needs and backgrounds. We work hard to make sure everyone can access and use our information and services, that our written material is easy to read and understand, and that our processes are simple.

We do our best to assist everyone who contacts us – there are ‘no wrong doors’ at the MHCC. We listen with compassion, empathy and an open mind. We are person-centred and seek to understand what is most important to the person in resolving their complaint. We treat all people with respect, dignity and courtesy, and embrace diversity.

We keep individuals and services informed about actions and outcomes through regular communication. Our decisions are based on fair and transparent processes and evidence, and our practices are consistent.

We understand the importance of good relationships and communication. We work together with individuals, carers, families, services and other stakeholders. We share what we learn. We use our resources and information to influence positive change.

We always look for ways to learn and improve. We ask people what their experience was like when they interacted with us, and use this information to improve our approaches. We are informed by the most up-to-date information about mental health and best practices in mental health services, and in complaint resolution.

“

The MHCC treated me with dignity and respect and, most importantly, they displayed empathy towards my circumstances which validated my experience and gave me hope.

It was great to be pointed in the right direction for seeking a resolution to the difficulty I have been confronted with as a result of being a client of a mental health service provider. I am grateful to have had a friendly and compassionate person listen to the distress I feel.

Thank you MHCC.”

- Consumer

To fulfil our statutory functions, we have established four main operational areas and built a diverse team of 15 equivalent fulltime staff. Additional contract staff were engaged to assist with specific establishment and developmental tasks. Many of our team members have experience in the mental health system as consumers, families, carers and employees. All share a common commitment to making a positive difference through our work, and work collaboratively to do so. Our four operational areas are:

This team receives and responds to enquiries and complaints made to the MHCC. They provide assistance to people raising concerns about public mental health services and referrals for complaints which fall outside our jurisdiction. They assess issues raised in complaints, and work with consumers, families, carers, and services to resolve complaints in ways that support recovery and improve services. Their work involves using informal and formal dispute resolution approaches as appropriate, and making recommendations on actions which aim to prevent a reoccurrence of a similar issue or event occurring. As part of the MHCC's safeguarding role, they identify quality and safety issues which may require review and further action, such as escalation with the service or investigation.

This team provides legal and other specialist advice for all areas of our work, including advice on any quality, risk and safeguarding issues identified in complaints, and works on complex matters and investigations. The team provides input into the development of best practice approaches to complaint resolution and investigation. Through case review and policy development, the team ensures our approaches appropriately address the principles and requirements of the Act, the Charter and other relevant legislation.

This team works to promote awareness of the MHCC and the role of complaints in safeguarding rights and improving people's experiences with services. It is responsible for providing advice, information and education on effective approaches to complaints and complaint policies and procedures. It develops resources and programs to help address barriers to people making complaints and promotes best practice complaint resolution. This team also promotes strong engagement with stakeholders by seeking ongoing feedback and support to ensure we meet the diverse needs of consumers, carers and services.

This team manages the business processes required to run the office effectively, including finances, information technology and human resources. It is responsible for developing data, evaluation and other operational systems to enable us to report effectively on the complaints made to the MHCC and the complaint reports received from services. The team will also undertake strategic projects to explore systemic causes of complaints. The information from their data analysis and strategic projects will be used to inform recommendations, submissions and reports to help drive systemic improvement.

03

Safeguarding rights and upholding the mental health principles

Our role

Our key role in safeguarding the rights of people receiving assessment and treatment in public mental health services underpins all our work. We work closely with the Chief Psychiatrist, the Mental Health Tribunal, the Public Advocate and Community Visitors to ensure the rights of people accessing mental health services are protected and upheld. We have established strong working relationships with these bodies, and refer issues to them and to the Australian Health Practitioner Regulation Agency (AHPRA) as appropriate.

Like all services, we are required to give effect to the new rights-based framework and the mental health principles in the Act. As a public authority, we are also required to consider human rights under the *Victorian Charter of Human Rights and Responsibilities Act 2006* (the Charter).

Our approach

In the Act's first year of operation, we have worked with consumers, families, carers and services to identify how the rights, principles and provisions of the Act can be used to resolve complaints and improve outcomes.

As the following examples show, we reviewed all enquiries and complaints to identify issues relating to risk, safety and rights under the Act, and escalated such issues for action or investigation under our own powers or by the service or other bodies as necessary.

Right to make a complaint

The right to make a complaint is essential for protecting all other rights, providing a critical safeguard for preventing and addressing alleged harms and rights breaches.

The Act requires services to provide the Mental Health Complaints Commissioner with reasonable assistance to perform our functions and exercise our powers. It also prohibits services from taking detrimental action against any person who makes, or intends to make, a complaint to us. Importantly, the Act also requires services to implement processes for resolving complaints locally.

We have promoted these rights and responsibilities through our education and engagement work. In dealing with enquiries and complaints, we have worked directly with consumers, families and carers to help them understand and exercise their right to complain. When a person raises a concern about alleged or potential detriment suffered as a result of their complaint to us, we have escalated this as a priority issue for review and potential investigation.

In our first year, we commenced an investigation into one such complaint to consider the alleged impact on access to service and to make recommendations on the service's approach to complaints if appropriate. We also made a submission on the draft Quality and Safeguards Framework for the National Disability Insurance Scheme, highlighting the importance of the right to complain and the need for independent complaint processes for safeguarding rights and quality in services.

Over our first year, we identified particular concerns about the use of restrictive interventions in emergency departments, and questions about the adequacy of reporting, oversight and safeguards in respect of these practices. Following discussions with the Department of Health and Human Services and the Chief Psychiatrist, we formally referred this issue to the department for review and consideration of the overlapping jurisdictions of the Chief Psychiatrist, the Health Services Commissioner and the MHCC. We will seek to contribute to such a review, and to the broader strategies being implemented by the department and services to reduce restrictive practices. The 10th National Seclusion and Restraint Reduction Forum in which we participated in May 2015 provided a useful platform to discuss contemporary best practice and current challenges. We will continue to inform our approaches to complaint resolution and the collection of more specific data to contribute to this critical area of service improvement.

MENTAL HEALTH PRINCIPLE

People receiving mental health services should have their rights, dignity and autonomy respected and promoted.

Section 11(1)(e) of the Mental Health Act 2014.

Dignity, safety and protection from harm

Complaints about people's experience of restrictive practices often raise issues relating to the right to dignity and safety. A person's right to be safe, and feel safe, in a service requires attention to individual needs and proactive strategies to provide protection from potential harms. The Charter also requires consideration of a person's right to humane treatment when deprived of liberty in environments such as locked inpatient or high dependency units, or when restraint or seclusion is used.

In keeping with our safeguarding role, we give particular attention to enquiries and complaints that raise issues of risk, safety and alleged harm. During our first year, we dealt with a number of complaints involving alleged assaults and harm caused by staff or other consumers, concerns about gender safety, and adverse events including injuries, near misses and critical incidents. While these represent only a small proportion of complaints to our office, incidents of harm demand priority attention and require a co-ordinated approach with services and other bodies. We are mindful of the need to tailor our approach to individual needs, while ensuring appropriate action is taken to address the quality and safety issues identified in the complaint.

In cases involving risk, safety or alleged harm, we assess the adequacy of the service's immediate and longer-term response, including any investigation and reporting to police. We also assess the steps the service has taken to respond to the individual's needs, to address risk issues and to prevent a reoccurrence. The action we take is informed by this assessment and consideration of the roles of other bodies such as Australian Health Practitioner Regulation Agency (AHPRA), the Coroner, Victoria Police and the Chief Psychiatrist.

In our first year, we have identified a variance in the way services approach reporting, investigating and reviewing incidents and the use of open disclosure in relation to adverse events. We have begun discussions with the Department of Health and Human Services and the Chief Psychiatrist on options for addressing these areas, including the development of practice guidelines for services when responding to allegations and undertaking investigations. This future area of work will be informed by our review of service reports on investigations and findings from our own investigations about complaints involving serious incidents and allegations.

As at 30 June 2015, we were completing an investigation into a complaint about a service's response to an alleged assault and assessing three other complaints involving incidents and injuries in inpatient units for possible investigation. We were also awaiting responses from two services about proposed undertakings to the MHCC to enable follow up on the steps taken to address safety issues identified in complaints.

Example complaint

Please note: The person's name has been changed and some details omitted to protect the identity of those involved.

COMPLAINTS LEADING TO IMPROVED PROCESSES

Through making a complaint to the MHCC, 'Wendy' was able to help improve a service's critical incident management in relation to inpatient contact with the police.

Wendy's complaint was that when she was a compulsory patient in a service, she was prevented from speaking to police following an alleged assault by a co-patient. She reported to the MHCC that, while she was eventually able to speak with the police, she had been distressed by the initial response from service staff. The service indicated that staff were concerned that Wendy wasn't well enough at the time to speak with the police.

Through working with Wendy and her complaint, the MHCC identified the need for the service to develop a new policy so staff were clear about their obligations to ensure appropriate responses were in place to protect patient safety, and to help consumers exercise their right to communicate with others outside the service.

The service made an unreserved apology to Wendy and advised that their staff would undertake new training in preventing and responding to incidents.

In this way, Wendy's complaint has led to tangible improvements that will benefit and protect current and future consumers.

² Victorian Department of Health and Human Services and Centre for Psychiatric Nursing, University of Melbourne

³ Victorian Department of Health, *Service guideline on gender sensitivity and safety*, State Government of Victoria, 2011

MENTAL HEALTH PRINCIPLES

People receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.

Section 11(1)(f) of the Mental Health Act 2014.

People receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to.

Section 11(1)(g) of the Mental Health Act 2014.

Aboriginal people receiving mental health services should have their distinct culture and identity recognised and responded to.

Section 11(1)(h) of the Mental Health Act 2014.

Children and young people receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible.

Section 11(1)(i) of the Mental Health Act 2014.

Children, young people and other dependents of people receiving mental health services should have their needs, wellbeing and safety recognised and protected.

Section 11(1)(i) of the Mental Health Act 2014.

Provision of holistic and individualised care, and the recognition of the needs of children and young people

A number of the complaints we received related to consumer concerns about whether their individual needs, including those of culture, language, communication, age, disability, religion, gender and sexuality had been met. We also received complaints from consumers and carers expressing concern that consumers' holistic needs, including health and alcohol and drug related needs, had not been met while receiving mental health services.

Many of these complaints occur when people are compulsory inpatients and unable to access their usual community supports or services, or where people need additional support to access appropriate services. We are often able to resolve these complaints in the early stages by supporting the person to communicate directly with the service about their needs. In others, we have actively engaged services on the need to develop coordinated treatment and care plans with other services, such as disability services, to respond to specific needs identified in complaints.

The Act also requires services to recognise and promote the best interests of children and young people, and recognise and promote their wellbeing, needs and safety. This requires services to adopt a holistic and individualised approach to care and treatment planning. For example, services have agreed to adopt tailored approaches to visits by children during a parent's inpatient admission and reconsider approaches to discharge planning for consumers with parental responsibilities.

Our experience dealing with complaints about services to young people and our visits to all Victorian public youth mental health services, including youth prevention and recovery centres (YPARCs), has reinforced the importance of such tailored and individualised responses.

We are also mindful of the need for dedicated attention to the needs of Aboriginal and Torres Strait Islander (ATSI) people, lesbian, gay, bisexual, transgender and intersex (LGBTI) people, people from cultural and linguistically diverse (CALD) backgrounds, and people with disability and age related needs and we will be developing tailored engagement strategies for these groups.

Our experience dealing with complaints about services to young people and our visits to all Victorian public youth mental health services, including youth prevention and recovery centres (YPARCs), has reinforced the importance of tailored and individualised responses.

MENTAL HEALTH PRINCIPLES

Carers (including children) for people receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible.

Section 11(1)(k) of the Mental Health Act 2014.

Carers (including children) for people receiving mental health services should have their role recognised, respected and supported.

Section 11(1)(l) of the Mental Health Act 2014.

Right to communicate privately with people outside a service

The Act sets out the right for people to communicate with people outside a service, and requires staff to ensure reasonable steps are taken to support such communication.

The MHCC received a number of enquiries and complaints about the lack of access to or confiscation of mobile phones, tablets or laptops from consumers during inpatient admissions. We identified variable practices across services. We questioned whether all practices were consistent with the rights and requirements of the Act, including the principles of the least restrictive treatment and recovery-oriented practice. Following discussions with the Department of Health and Human Services and the Chief Psychiatrist, we have formally referred the need for policy and practice guidance on access to mobile phones and other communication devices for consumers during inpatient admissions to the department for consideration.

We have also identified a small number of complaints where a person has not been supported to contact, or has been prevented from communicating with, a person or agency (for example, the police) in the absence of a direction to restrict communication by the authorised psychiatrist. We have started to educate services about their responsibilities in relation to this right, and have made recommendations to a number of services to review their policies and procedures to ensure they comply with the Act.

Recognition and respect of the role of carers and consultation with carers about key decisions for compulsory patients

The recognition of the role of carers and acknowledgment that carers should be involved in decisions about assessment, treatment and recovery wherever possible are significant changes to the Act, and are important for promoting supported decision making. The Act requires services to notify and consult with carers of compulsory patients about key decisions which may impact on the care relationship.

In dealing with enquiries and complaints from carers, we have identified the need for services to develop new approaches for hearing and responding to the concerns of carers, and implementing processes to ensure carers of compulsory patients are notified and consulted as required by the Act. As an outcome of complaints made to the MHCC, two services formally reviewed their policies and practices to ensure that carers were appropriately notified and involved in treatment and care decisions.

Most of the complaints we receive from carers are made with the agreement and support of the consumer and the outcome most commonly sought is improving the consumer's experience of future care, as well as the carer's experience of interacting with the service. There are times when the MHCC is unable to directly deal with a complaint made by a carer due to the requirement under the Act that we seek the consent of the consumer to a complaint, or assess that there are special circumstances to deal with the complaint and that this will not cause detriment to the consumer's wellbeing. As the Act requires a consumer to be notified if we accept a complaint, we also discuss whether accepting the complaint without the consumer's consent would impact on the care relationship. Where we are unable to formally deal with a complaint, the Act provides the option of providing assistance to the person to resolve their complaint directly with the service.

We have supported carers to make complaints directly to services about their experiences, provided advice and guidance to carers about how to navigate a complaint process, provided advice to services about the rights of carers under the Act, and facilitated complaints back to the service for local resolution.

Example complaint

Please note: Names and some details have been omitted to protect the identity of those involved.

The mother of a son who was recently diagnosed with schizophrenia rang because she wanted to provide extra information to a service. She felt that her son was presenting well, but was not really coping. As his carer, she wanted the service to know of her concern. She had left messages for her son's case manager, but had not received a reply. She did not want to talk to her son about making a complaint as he was ambivalent about receiving treatment.

We discussed how services are required to involve carers wherever possible and that they should have a process for hearing concerns and receiving information from carers. We helped her raise her concerns directly with the service and obtained a commitment from the service to address the issues about the lack of response from the case manager. After we identified the appropriate manager within the service, the mother spoke with the treating team and outlined her concerns so they could consider them in their discussions with her son about his treatment options.

Advance statements, nominated persons and second psychiatric opinions

The Act introduced important supported decision-making approaches for a consumer to make an advance statement about their treatment preferences, to nominate a support person to receive and provide information about treatment and care while a compulsory patient, and to have access to a second psychiatric opinion. Some complaints received by the MHCC related to a consumer's concerns about how a service considered, used and responded to these mechanisms in providing care and treatment. In some instances, where the person has been very unwell or had difficulty expressing their views and preferences, the MHCC has sought an explanation from the service about how they considered the person's views and preferences.

We have also promoted consideration of advance statements, the appointment of nominated persons, and requests for second psychiatric opinions that can help resolve complaints and prevent a reoccurrence of the concerns raised. Many services have also proactively sought to discuss these options with people when working to resolve a complaint. In a number of complaints received by the MHCC, we have seen how services have been able to restore a person's confidence and trust in the service by taking steps to understand the person's experience and engage with their views and preferences for any future treatment and care.

04

Building awareness and capacity through education and engagement

Our role

Education and engagement are essential to all our work and statutory functions. The Act requires us to provide information and advice to services about their responsibilities in responding to complaints and to help services improve their complaint policies and procedures. The Act also requires us to make information on our complaint processes available and accessible. In carrying out these functions, we work to ensure consumers, families and carers understand our role and are aware of their right to complain under the Act, and build their confidence to make complaints direct to services and to us. Across all this work, we demonstrate how a positive culture of complaints can inform and drive service improvement.

Our approach

Building on the consultations by our establishment team, our work has been informed by the need for proactive strategies to address the fear and other potential barriers that may prevent people from making complaints.

In our first year, we have focussed on building awareness of the Mental Health Complaints Commissioner and the role of complaints in safeguarding rights and improving people's experiences with services. Our key messages, 'Speak up. Your experience matters' and 'Speaking up improves services for everyone', were developed in discussions with consumers, families and carers.

Our education and engagement work with services aims to support cultural change in the way services approach complaints, promoting a 'positive complaint's culture' in all services. Our aim is to support services to create an environment where consumers, families and carers feel supported to speak up about their concerns and help services respond in a way that encourages system improvement across the public mental health system.

Overview of education and engagement activities

We planned and implemented a range of direct and indirect activities to promote awareness and accessibility and to expand our reach and connection with people and services throughout Victoria.

We undertook 135 direct education and engagement activities where we reached nearly 11,000 community members and stakeholders. They included a range of conferences, forums, meetings and community events, with the Commissioner reaching more than 3,000 participants through her presentations at 50 events, as well as two radio interviews (Evenings with Lindy Burns on 774 ABC and Living Black on SBS Radio). See **Appendix 2** for details of these presentations.

Promoting awareness and accessibility

In planning our education activities, we were conscious of the need to address potential barriers to people making complaints, and to promote awareness of our key messages and the role of the office. We have developed both broad and targeted campaigns, with the aim of reaching individuals and groups who may not otherwise receive this information. To this end, our outreach activities included actively participating in International Day for People with Disability, Mental Health Week, Midsumma Festival, Chill Out Festival, Change Day and the Ageing in Australia Expo 2015. We also conducted our own Better Mental Health art competition to support Mental Health Week, and supported the Action on Disabilities within Ethnic Communities (ADEC) Artability visual arts program and the Monash Health Mental Health Week Art Competition.

We have distributed approximately 25,000 promotional and information products through these outreach activities and through services, and we are using feedback from services and community members to develop these products and enhance accessibility. Our printed and online materials explain our complaints role to consumers, carers, families, other community members and services.

Using new ways of communicating

Promoting awareness and accessibility of our office has also involved using new ways of communicating, including social media. Social media allows us to participate in different conversations about complaints, mental illness, and other complaint bodies similar to the MHCC. It helps us to promote participation from our community and encourages us to be accountable.

We are steadily building a social media presence and have received positive feedback for our presence. Facebook, with 2,300 followers and counting, is becoming another digital channel that supports initiatives to reduce the social stigma surrounding mental health, promote our work and reinforce our key messages.

Our website also provides an easy way of communicating with many of our communities and stakeholders. We are planning to redevelop the site to enhance accessibility and make it easier for people to bring complaints to us.

Engaging with consumers, families and carers

We pride ourselves on taking a collaborative approach to our work, and keeping ourselves accountable to our community partners through regularly seeking their feedback.

During our first 12 months, a key priority was to engage with consumers, families, carers and advocacy organisations to explain our role and demonstrate our open and accessible approach. We were also determined to continue listening to the voice of consumers, families, carers and services, and drawing on their advice and insight to establish and improve our own practices.

We created many opportunities for people to participate directly with us. This included seeking a range of opinions to develop our key messages and visual identity. We engaged people through art competitions and used our social media channels to encourage conversations about speaking up.

To this end, we initiated or participated in a range of specific information and education sessions where we outlined our role, the right to make a complaint under the Act, and promoted new approaches to complaints with the aim of improving experiences for individuals and recommending system improvements for services.

We found participants genuinely interested in our work, with many people bringing their individual concerns and questions to our staff. All were keen to hear about our progress, and very interested in the number and nature of complaints to our office.

Importantly, all forums enabled us to learn and explore the many issues affecting consumers, families, carers and staff. Specific forums included VMIAC (Victorian Mental Illness Awareness Council) and Tandem (representing Victorian Mental Health Carers) and local and regional carer and consumer forums (for example, the South West Carer and Respite Services Network Forum).

A challenge that we face is that there are many cultural and language barriers for people in the public mental health system, and we will be working strategically to make our role known to people from culturally and linguistically diverse (CALD) backgrounds and Aboriginal and Torres Strait Islander people.

Building relationships with services

Good relationships with services are critical to the success of our work, with their understanding and support crucial to securing effective resolutions to complaints and driving lasting service improvement. With this in mind, a key priority was to meet with clinical and executive directors and staff from every public mental health service in Victoria to learn about their challenges and the work they are doing to support people's recovery.

We made 123 service visits during the year, talking with and listening to every Victorian designated public mental health service and many mental health community support services. We met with almost 500 staff and just over 100 consumers and carers during these visits. These visits enabled us to see and hear firsthand the unique challenges they face and the different approaches they are taking to supported decision making, recovery-centred care and complaints. They also enabled us to explain our role and the new service reporting requirements, as well as discuss the opportunities to work together to promote system improvement. We also introduced our education role and sought services' views on the types of education and resources that would best support their staff to respond effectively to complaints.

We have appreciated talking with staff and hearing the personal stories of many consumers and carers. All MHCC staff participated in our schedule of visits to broaden their understanding of the public mental health system and foster positive and productive relationships with service staff. See **Appendix 3**.

Educating on new approaches to complaints

Through our presentations to a range of audiences, and through our visits to services, we have sought to communicate our key messages and introduced the 'Four A's' of complaint resolution: Acknowledgement, Answers, Actions and Apology. This framework is based on research about the four most common things people seek when they make a complaint.

This approach to complaint resolution has been successfully delivered by the Disability Services Commissioner over many years, and is consistent with open disclosure in health services.⁴ It focuses on providing effective responses and creating the opportunity for the complaint to lead to improved outcomes for the individual and the service. Our proposal to use this framework for developing education sessions for staff in mental health services has been very well received by services, as well as by consumers, families and carers, and we look forward to working with stakeholders in the development of these sessions.

The Four A's of Complaint Resolution

Acknowledgement	People want their concerns to be heard and acknowledged, and the impact of their experience to be recognised and understood. Acknowledgement of their rights and what should have occurred in a situation can also be important.
Answers	People are usually looking for an explanation as to why something has happened or not happened, or why a certain decision was made. For answers to be meaningful, they need to be provided in a way that can be readily understood by the person and that encourages the person to ask further questions if needed.
Action	People will generally be seeking action to address their individual issue or a change to be made to improve their experience and treatment. Many people also make a complaint because they don't want the same thing to happen again for themselves or other people, and want services to take actions to achieve this.
Apology	A meaningful apology normally involves acknowledgement, answers and actions by a service and when appropriate, can assist in a person's recovery and help to restore confidence in the service.

Engaging with other stakeholders and sector forums

We have also sought to build awareness of our role and strong relationships with stakeholders and other organisations to promote effective referrals and work on common goals. To this end, we have provided presentations to a range of stakeholder, professional and community forums. We have also participated in sector forums to ensure our work is informed by current and emerging issues and developments in mental health and related sectors. Examples include participation in the Rural and Remote Mental Health Conference, and presentations to the Regional Convenors of the Community Visitors Program, the Victorian branches of the Australian Medical Association and the Australian Nursing and Midwifery Federation.

⁴ 'Open disclosure' is the process of open discussion with a patient, and or their family/support person about an incident(s) that resulted in harm to that patient while they were receiving healthcare. <http://www.health.vic.gov.au/clinrisk/opensdisc.htm>

05

Providing new avenues and approaches to resolving complaints

Our role

The Act gives the Mental Health Complaints Commissioner broad powers to deal with complaints in relation to designated mental health services and publicly funded mental health community support services. This includes NDIS funded supports and services that fall within the broad definition of a mental health community support service.

The Act provides for individualised approaches to dealing with complaints, giving the MHCC the option of:

- helping people resolve complaints directly with the service
- using informal and formal resolution processes, including reviewing the responses of services, facilitating conferences and confirming agreements on actions
- seeking formal undertakings from services on actions to address the issues
- referring the complaint for conciliation
- providing advice and recommendations to services
- investigating matters or issuing compliance notices where appropriate.

These options give the MHCC the flexibility to choose the most appropriate approach for each complaint.

Legislative requirements

Under the Act, the MHCC can accept complaints about a person's experience with a service, including complaints about accessing a service, treatment and care. The Act allows us to accept complaints from a consumer, a person who is acting at the request of a consumer, or anyone who has a genuine interest in a consumer's wellbeing. The Act also enables the MHCC to accept complaints without the consumer's consent, where we are satisfied there are special circumstances and accepting the complaint will not be detrimental to the consumer's wellbeing. When this occurs, the MHCC must still advise the consumer about the complaint and seek their views on resolution.

The MHCC is required to assess written complaints made to us and make a decision to formally accept or close the complaint within 20 business days of receipt of the complaint. To meet this timeframe, we make a baseline assessment that considers our jurisdiction and whether the consumer consents to the complaint.

Our approach

Our approaches to complaints have been developed to reflect the objectives and principles of the Act. They are guided by our own principles and informed by the key themes from our establishment consultations, alternative dispute resolution theory and best practice approaches in complaint handling and investigations.

As outlined in Section 3, we assess every complaint with reference to the rights and requirements in the Act, including the mental health principles. Our overall aim is to resolve complaints in ways that support recovery and improve services.

Our key process objective is to ensure people feel heard and respected and are confident their complaint has been taken seriously. We endeavour to provide a 'person centred' process that reduces fear and builds the confidence needed for a person to raise complaints directly with the service in the future. We try to support the person and the service to gain a mutual understanding of the issues and reach agreement on ways in which they can be addressed and resolved. In working with services, we seek to support them to provide effective responses to complaints, taking into account the Four A's of effective complaint resolution: acknowledgement, answers, action and apology (see Section 4).

A NOTE ABOUT OUR DATA

In order to commence operations, the MHCC adopted a legacy case management system (CMS). This was intended to be a short term measure while a customised CMS was built. The legacy system has been in place for 2014-15, limiting our data set. For example, the majority of complaints made to the MHCC involve multiple issues, all requiring attention for effective resolution. Our capacity to capture and analyse the detail of these issues has been constrained by our legacy CMS which limits the number of issues and categories that can be recorded. Our breakdown on issues identified in complaints is therefore confined to the main presenting issue in each complaint. To supplement this analysis, we undertook a thematic and content analysis of issues identified in a sample of 132 accepted cases (13 per cent of all complaints). These results are also included to provide a clearer indication of the frequency of issues raised in complaints. Our new CMS is almost complete and will enable us to better capture and analyse our data in future reports.

Enquiries and complaints to the MHCC in 2014/15

Overview

In our first 12 months of operation, the MHCC received 1,456 enquiries and complaints about Victorian public mental health services, comprising 457 enquiries (31 per cent) and 999 complaints (69 per cent) – see **Figure 1**. These matters commonly required multiple contacts from consumers, carers and services. We received 6,931 calls to our 1800 number and 3,376 pieces of correspondence relating to enquiries and complaints.

This level of engagement was much higher than the pre-establishment estimates of demand. In 2013-14, the Chief Psychiatrist and the Health Services Commissioner dealt with complaints about public mental health services, receiving 410 and 180 complaints respectively.⁵ Demand has severely tested our resources and affected the timeliness of some of our resolution processes. The significantly higher number of matters raised with the MHCC suggests the importance of having an independent, specialist complaints body, and the success of the approaches we have adopted to promote accessibility and confidence in our office.

In our first year, we responded to a range of enquiries from people seeking information, advice or assistance. Many people contacting the MHCC are experiencing severe distress and other challenges, and their enquiries require a sensitive and considered approach, often involving multiple contacts. We have also promoted the message that people can contact the MHCC to seek information and advice about making a complaint, to help mitigate against some of the potential barriers people may experience. Enquiries have also included requests for information about the role and jurisdiction of the MHCC and the new Act, and requests for assistance with referrals or access to services. During the period of recommissioning mental health community support services and transitioning to new services (from August 2014), we also received enquiries and questions about these changes and potential impacts.

⁵ Office of the Health Services Commissioner 2014, *Annual Report 2014*, State Government of Victoria, Melbourne, p.31.
Chief Psychiatrist, *Chief Psychiatrist's annual report 2012-13 and 2013-14*, State Government of Victoria, Melbourne, p.22

THE MHCC HAS ADOPTED THE FOLLOWING DEFINITIONS FOR ENQUIRIES AND COMPLAINTS.

An enquiry is a request for information, advice or assistance.

Enquiries to the MHCC can include requests for information about accessing services or advice about how to make a complaint.

A complaint is an expression of dissatisfaction about a service for which a response is explicitly or implicitly expected from the MHCC (based on Australian Standard 1002-2006, ISO 10002-2004).

Complaints can be made orally or in writing. To be formally accepted, they need to be made or confirmed in writing.

Figure 1

Breakdown of enquiries and complaints made to MHCC

Base: All enquiries and complaints raised with MHCC, n=1,456
Enquiries - 457; Complaints - 999

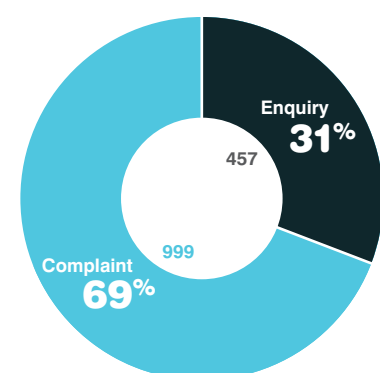
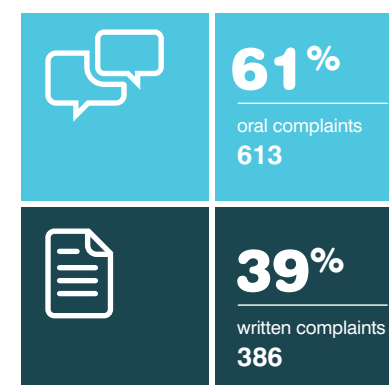


Figure 2

How complaints were raised

Base: All complaints raised with MHCC n=999



How we receive complaints

We receive complaints by phone, email, fax, letter, via our website or private message on Facebook and face to face. The majority of first contacts to the MHCC were made over the phone on our 1800 number. Seven per cent of all calls were made by prisoners on the dedicated phone line for prisoners concerned about mental health treatment in prisons.

Our commitment to promoting responsive and timely resolution of complaints means much of our work occurs over the phone responding to oral complaints. While the legislation requires a complaint to be confirmed in writing to be formally accepted, we seek to promote early resolution wherever possible. This means more than half (61 per cent) of complaints were dealt with as oral complaints, with a focus on promoting local and early resolution of concerns by providing a supportive process that ensures the person feels heard and supports them to resolve the complaint directly with the service (**Figure 2**).

In responding to oral complaints, we seek to clarify the person's concerns and gain their consent to contact the service to explore options for a direct response and resolution. This approach is more prompt for the person and the service, and gives the service the opportunity to respond in a way that builds the person's confidence and strengthens their relationship with the treating team. However, oral complaints often require significant time and skill on the part of the Resolution Officer who responds to callers in distress, assess complex issues, identify risk or safeguarding issues, confirm the agreed actions by the service or provide assistance to confirm oral complaints in writing. Many of the almost 7,000 calls received on our 1800 number during the year saw resolution team members facilitating an early resolution of complaints through clarifying issues and options with the person and the service. This meant that issues were often resolved without requiring a formal written complaint. We do, however, also provide assistance to confirm complaints in writing, so we can formally accept and deal with complaints where an early resolution process is not possible or appropriate for the issues raised. This approach to dealing with oral complaints reflects the feedback from consultations by our establishment team and is consistent with the Productivity Commission's recommendations on complaints processes from their Inquiry into 'Access to Justice Arrangements'.⁶

⁶ Productivity Commission 2014, *Access to Justice Arrangements: Overview*, Inquiry Report No. 72, Canberra

⁷ Chief Psychiatrist, Chief Psychiatrist's annual report 2012-13 and 2013-14, State Government of Victoria, Melbourne, p.23.

Example complaint

Please note: Names and some details have been omitted to protect the identity of those involved.

A mother rang MHCC distressed that a service was discharging her daughter without consulting her. We contacted the service, which advised that they had consulted the consumer's nominated person (a friend) and had not understood the consumer was returning to her parents' home and care. The service acknowledged they should have involved the parents in the discharge planning and that they needed to address this quickly due to the consumer's imminent discharge. By agreement, the service contacted the mother to apologise and discuss her concerns about the timing of her daughter's return home. The mother felt heard and supported by the MHCC's assistance in facilitating a direct resolution with the service. As an outcome of this complaint, the service involved the consumer, her nominated person and her parents in discussions about plans for discharge and treatment. This complaint identified the need for the service to recognise the different roles of people involved in supporting a consumer's treatment and recovery under the new Act.

People who made complaints

Consumers raised 71 per cent of enquiries and complaints to MHCC, and family members and carers raised 23 per cent. The remainder were made by advocates, legal representatives, friends and other services or referred from other bodies such as the Chief Psychiatrist, the Health Services Commissioner, the Disability Services Commissioner and the Office of the Public Advocate (**Figure 3**).

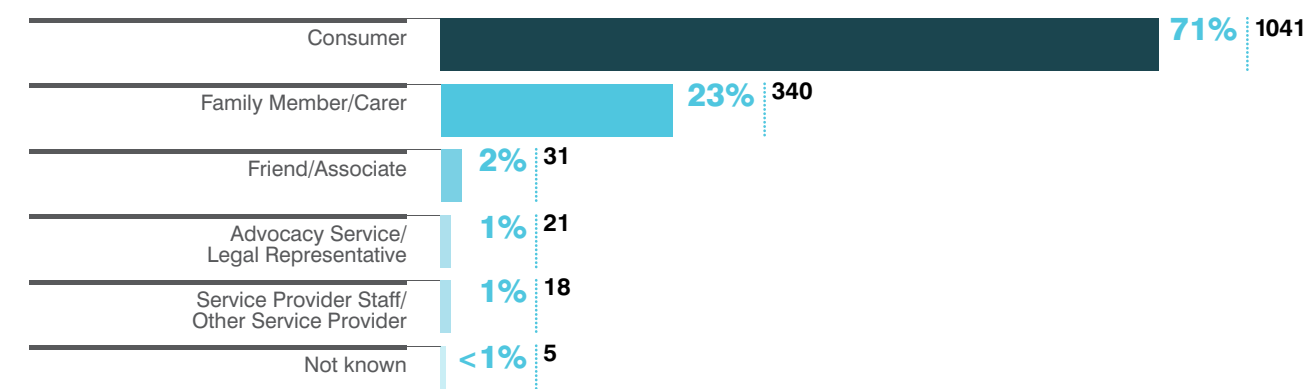
The proportion of consumers raising issues is much higher than under previous complaints mechanisms for the Chief Psychiatrist and the Health Services Commissioner (for example, 48 and 50 per cent of complaints to the Chief Psychiatrist in the years 2012-13 and 2013-14 were made by consumers).⁷ The number of family members and carers making complaints to our office is also higher than under previous mechanisms, with many also involved in supporting consumers who have made complaints directly to us.

The gender identity of people making complaints was split fairly evenly between females and males (52 per cent females compared to 48 per cent males), while the information available on consumers indicated a slightly higher ratio of males (52 per cent males compared to 47 per cent females). Gender identity was undisclosed for the remaining one per cent of consumers. Information on the age and cultural and linguistic backgrounds of people could not be reliably identified and collected in the CMS used in our first year, but will be addressed in future data analysis.

Figure 3

Source of enquiries and complaints

Base: All enquiries and complaints raised with MHCC, n=1,456



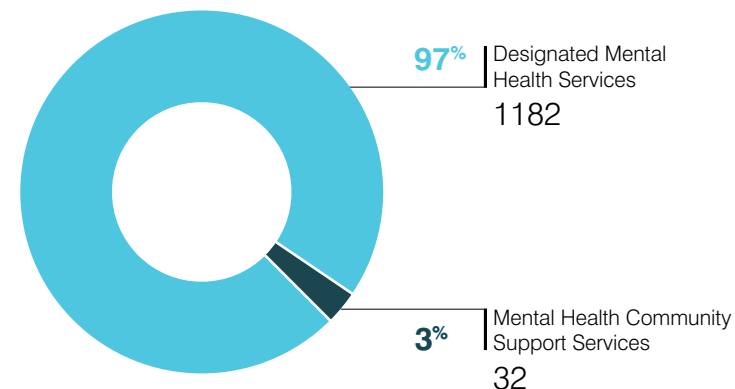
Type of service provider

The vast majority of enquiries and complaints made to the MHCC (97 per cent) related to designated mental health services, with only three per cent relating to mental health community support services. **(Figure 4)**

Figure 4

Enquiries and complaints made to MHCC by service program

Base: Enquiries and complaints raised with MHCC where information was recorded about service program, n=1,145



Service program types

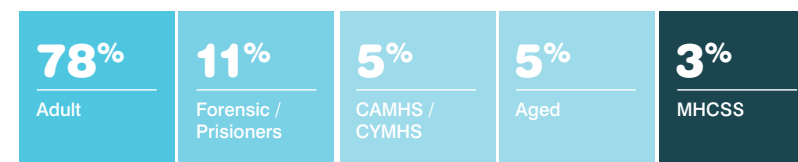
Of the enquiries and complaints made to the MHCC about designated mental health services, 78 per cent were about adult mental health services, 11 per cent were about forensic services (including services in prisons), five per cent were about aged mental health services, five per cent were about Children and Youth Mental Health Services (CYMHS)/Child and Adolescent Mental Health Services (CAMHS), and three per cent were about mental health community support services. **(Figure 5)**

Sixty three per cent of matters raised about adult services related to inpatient services (including secure extended care units and specialist inpatient services), with 28 per cent about community services (including community area mental health services or community care units). Complaints about aged care services and CYMHS/CAMHS were also much more likely to be about inpatient services (90 per cent and 78 per cent respectively) than community based services (10 per cent and 22 per cent).

Figure 5

Enquiries and complaints made to MHCC by service program

Base: Enquiries and complaints raised with MHCC where information was recorded about service program, n=1,145



Key issues identified in complaints

People contacting the MHCC about complaints (both oral and written) were most likely to identify their main issue as relating to treatment (37 per cent of all complaints) – see **Figure 6**. The analysis of multiple issues in accepted complaints indicated that concerns about treatment are likely to be present in over 60 per cent of matters **(Figure 7)**.

Concerns about communication, consultation and information were raised as the main issue in 19 per cent of all complaints. Communication issues were, however, identified in 40 per cent of accepted complaints analysed. Issues relating to staff behaviour and conduct were identified as the main issue in around 10 per cent of all complaints, but these issues were identified in 37 per cent of the accepted complaints analysed.

Similarly, concerns about access to services were raised in 11 per cent of all complaints, but were identified in approximately 20 per cent of accepted complaints.

Discharge and transition planning issues, concerns about the amenity, environment and management of facilities, and issues relating to complaint and grievance processes were identified as the main issue in approximately four per cent of all complaints. These issues were, however, identified in approximately 12 to 19 per cent of the accepted complaints analysed. Other less common issues included issues relating to privacy, consent, accuracy of medical records, and fees.

Treatment issues

Treatment issues most commonly related to concerns about the adequacy or effectiveness of treatment, including concerns about the extent to which the consumer's views and preferences were taken into account (15 per cent of all complaints). Other common treatment issues included concerns about the decision to provide compulsory treatment, disagreements and concerns about inadequate consultation about treatment plans (eight per cent), and views that the treatment being provided was excessive (four per cent). Treatment issues identified in accepted complaints included concerns and disagreements about diagnosis, and difficulties in accessing a second psychiatric opinion.

A range of specific issues relating to medication were also raised in complaints about treatment, with the most common concerns being the adequacy of consultation about medication options, insufficient information or consideration about side effects, and dissatisfaction with prescribed medication or changes to medication.

Communication issues

Communication, consultation and information issues generally related to insufficient consultation with the consumer, a family member or carer about decision making. This included concerns that care was not sufficiently person-centred to take into account the consumer's individual needs. These communication issues were often described in terms of services not listening adequately to the views of the consumer or carer. These issues also commonly related to concerns that information and communication was inadequate or incomplete, including failure to inform consumers or families about decisions, changes in treatment or other relevant information (five per cent).

Staff behaviour and conduct

Issues raised about staff behaviour and conduct included concerns about staff skills and competence, and perceptions of staff lacking empathy or respect in their interactions. A small number of complaints involved serious allegations of threatening behaviour and assaults, some of which occurred in the context of the use of restraint and seclusion. All complaints involving allegations of staff or practitioner misconduct were assessed for notification and referral to the Australian Health Practitioner Regulation Agency (AHPRA). The status of investigations by the police and the service were also considered in our assessment and dealing with these complaints.

Access to services

The most common access issues raised in complaints related to access to an inpatient admission or to a specialist assessment or service, such as treatment for eating disorders, borderline personality disorder or specialised services for children and young people. Concerns included decision-making processes and the information considered by services to determine eligibility for services.

Environment and management of facilities

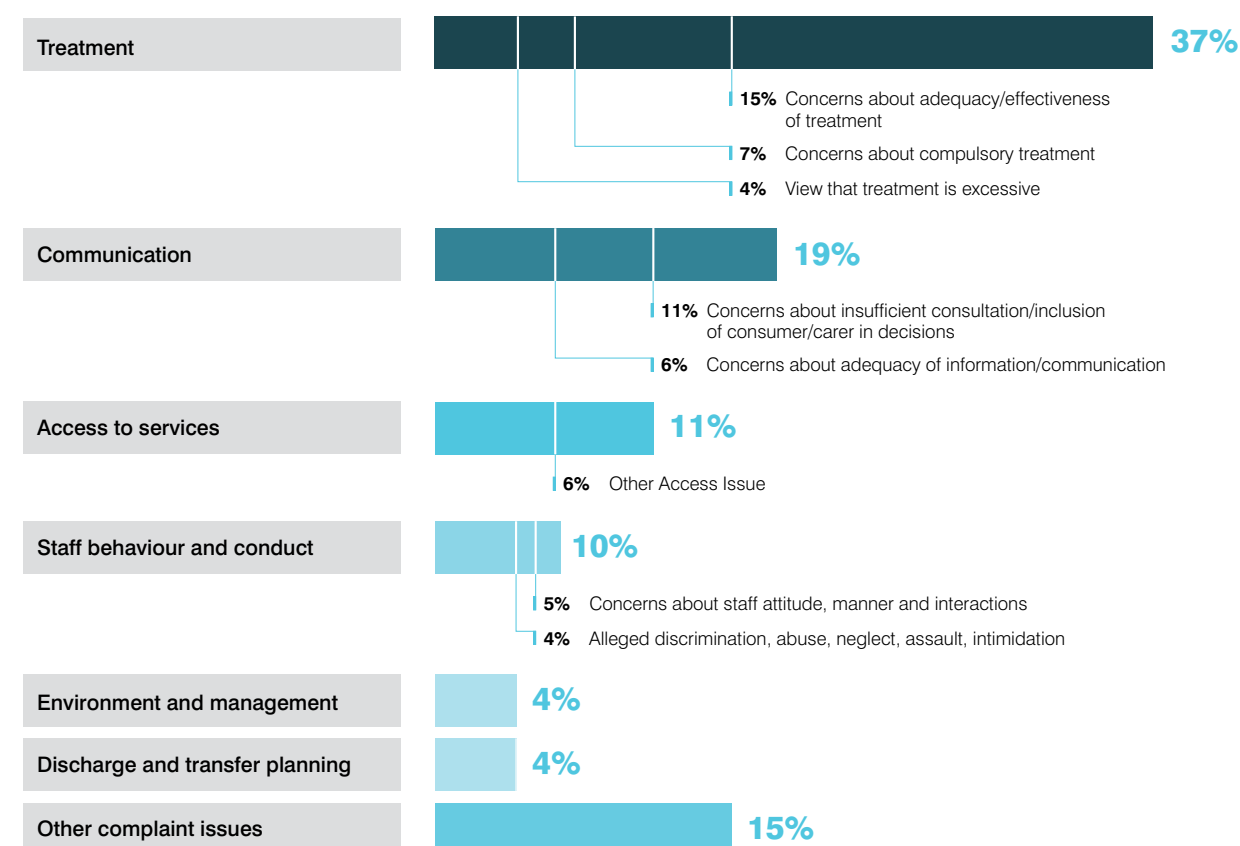
Issues raised about people's experience within facilities such as inpatient units included dissatisfaction with the physical environment of the facility, including its cleanliness, amenity and suitability for the individual needs of consumers (for example, gender sensitivity, privacy and mobility). Concerns also included the adequacy of activities, stimulation and programs provided.



Figure 6

Main issues* raised in complaints

Base: All complaints raised with MHCC, n=999; Main presenting issue only

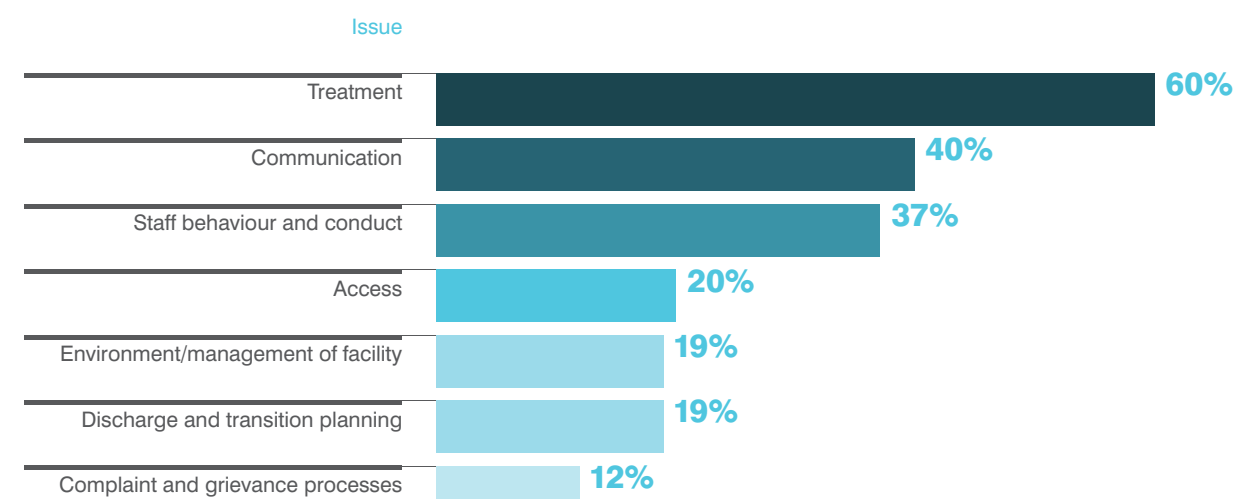


* This figure displays broad higher-level and sub level issues categories raised in at least four per cent of complaint matters.

Figure 7

Breakdown of issues identified in accepted complaints*
(Level 1 only-multiple issues per complaint)

*Based on thematic analysis of a sample of 132 accepted complaints- issues identified in at least 10 per cent of matters. Sample of accepted complaints received between 1 July 2014 and 8 April 2015.



Overview of outcomes

Of the 1456 enquiries and complaints received in 2014-15, 1183 were closed during the year. Thirty-eight per cent of all matters were closed within one week, 64 per cent were closed within one month and 90 per cent were closed within three months (**Figure 8**). These statistics reflect the high number of oral complaints and our capacity to use informal processes to achieve timely resolution. Ten per cent of complaints took more than three months to close, with the time taken extending up to a year for more complex matters. While the length of time taken generally reflects the complexity of the issues involved, it was also affected by the level of demand on our resources.

Of the 726 complaints which were closed in 2014-15, the majority were closed as oral complaints (73 per cent), with a further 19 per cent being closed in the preliminary assessment stage provided in the legislation for written complaints. The remainder were accepted complaints which were closed following further assessment and resolution processes. Of the 273 complaints which were open at 30 June 2015, 147 were accepted complaints in various stages of the resolution process, and two complaints were subject to investigation processes (**Figure 9**).

Figure 8

Time taken to close enquiries and complaints

Base: All closed enquiries and complaints, n=1183





Figure 9

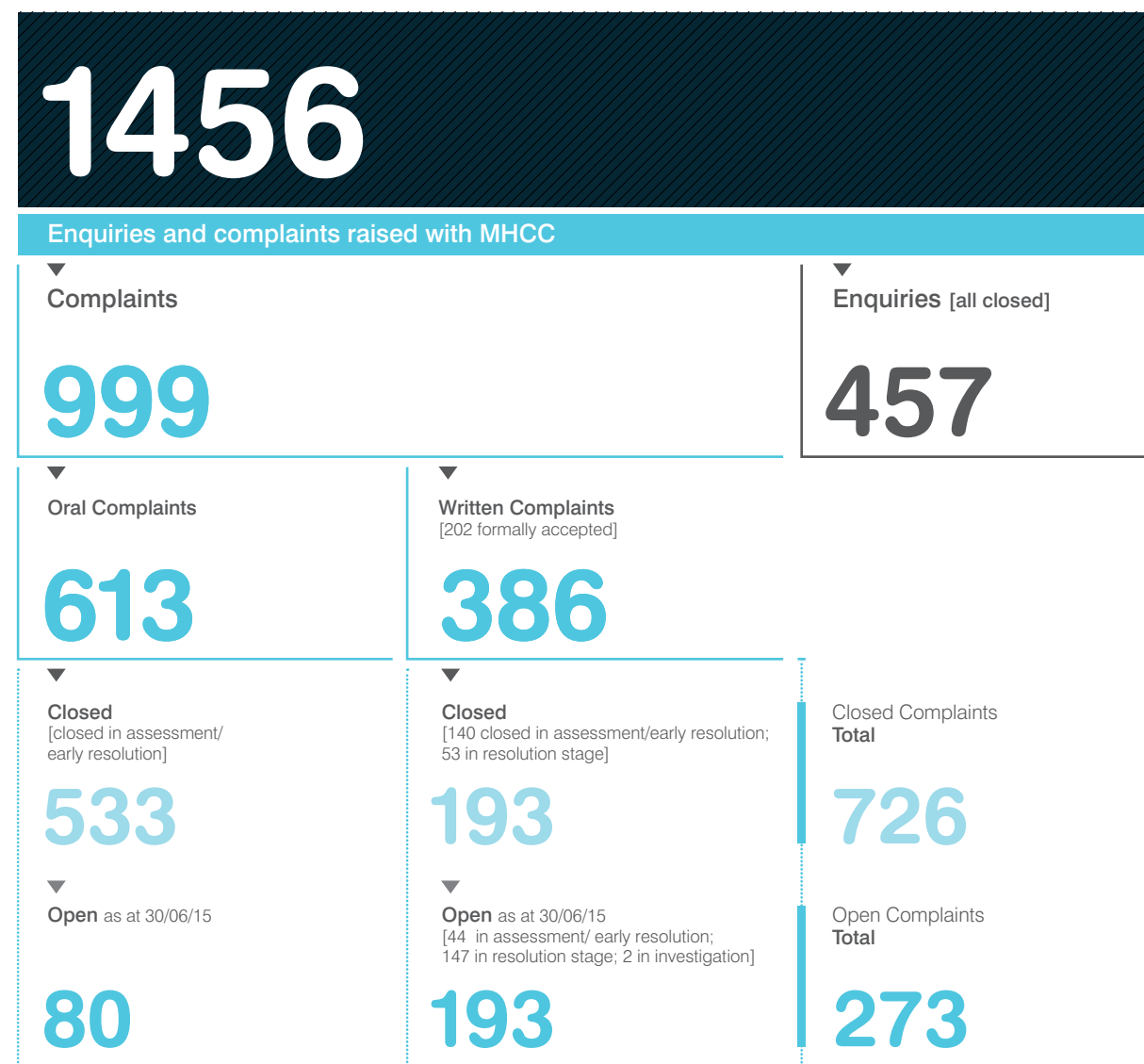


Figure 10

Overall complaint outcomes

Oral and written complaints. n=999

	100% [999]		
% of complaints	42%	31%	27%
number of complaints	416	310	273
status of complaint	in scope complaints where resolution actions taken	complaints assessed as resolution actions not applicable/possible	complaints still open as at 30 June 2015

Figure 11

Resolution outcomes: *In-scope* complaints where resolution actions were taken

Oral and written complaints. n=414

	100% [414]		
% of resolution outcomes	55%	35%	10%
number of resolution outcomes	266	144	44
	resolved fully or substantially	resolved partially	not resolved

Overall outcomes for complaints

In order to assess the types of outcomes achieved in both oral and written complaints, we identified the number and proportion of complaints that were out of jurisdiction ('out of scope') due to timing or type of service or where there were other reasons where the MHCC resolution processes could not be provided (**Figure 10**). These matters were grouped as 'Resolution actions not applicable/possible'.

In addition to complaints which were out of jurisdiction for the MHCC, other reasons for not providing a resolution process included matters which were more appropriately dealt with by another body such as the Mental Health Tribunal (for instance where the key issue was a complaint about compulsory treatment), or where circumstances changed, the complaint was withdrawn, or there was no further contact from the person. In all these matters, assistance was still provided in terms of information and referrals to address the concerns raised. In 2014-15, 31 per cent of complaints (310) were assessed in this category, with the most common reasons being that the complaint was out of jurisdiction (14 per cent) or no further contact (13 per cent). Cases of no further contact from the person were most commonly associated with situations where a person had been discharged from an inpatient admission or a compulsory treatment order.

'In-scope' complaints are defined as those complaints for which the MHCC undertook resolution actions to address the issues raised. The 416 'in-scope' complaints were reviewed for the outcomes achieved in order to identify the resolution rate achieved through MHCC processes.

Resolution outcomes

Of the 416 'in-scope' complaints which were closed in 2014-15, resolution outcomes were assessed according to the following three categories:

Resolved: This represents complaints where the issues were either fully or substantially resolved, or where there was agreement on the proposed actions to address the concerns raised and to close the complaint. Overall, the complaint achieved a positive outcome in terms of the person's current or future treatment.

Partially resolved: This represents complaints where the issues were partially resolved (either resolution of one or more of multiple issues, or partial resolution of a single issue). Partially resolved complaints also include those complaints where the service has committed to service improvement actions where it has not been possible to resolve the individual's concerns.

Not resolved: This represents complaints where there was a barrier to achieving a positive outcome from the complaint or agreement couldn't be reached on addressing the concerns raised. Examples of complaints that were not resolved include complaints about a past inability to access a service and dissatisfaction with explanation or actions proposed by the services.

When the outcomes were analysed for all complaints closed in 2014-15 (oral and written) more than half of complaints were resolved and a further 35 per cent received a partial resolution. Overall 90 per cent of 'in-scope' complaints achieved some positive outcomes as a consequence of our resolution process (**Figure 11**).

The overall resolution rate for oral and written complaints were similar (54 per cent and 56 per cent respectively), with almost a fifth (17 per cent) of written complaints resolved through seeking early resolution with the service without the need for formal acceptance of the complaint. In 42 per cent of complaints, the MHCC proactively assisted the person to resolve the complaint directly with the service.

How complaints were addressed and resolved

The positive outcomes that we have been able to achieve through the complaints process have occurred where:

- we have been able to help people resolve their complaint directly with the service
- services have acknowledged the person's concerns, and provided an apology where appropriate
- agreement has been reached between services and individuals on a range of actions to address the concern, including:
 - development of advance statements
 - review or changes to treatment/management plans
 - arranging access to a second psychiatric opinions
 - review or changes of workers
 - review of responses to incidents/events
 - review or development of policies and practices
 - staff training and supervision
- services have reviewed their responses, policies and practices to make improvements, including providing further support and training to staff.

Some of these outcomes have been achieved through facilitated meetings which have led to an improved understanding and communication of the issues with consumers, families, carers and services.

We also provided seven formal recommendations and advice to services to review policies or practices to prevent the issues identified in complaints from reoccurring and promote service improvements. Examples are provided in Section 7.

Our analysis of the range of actions taken to address and resolve complaints has been limited by the two levels of outcomes fields available on our legacy case management system. Nonetheless our data on the outcomes of the 416 'in-scope' complaints reveals that the most common resolution action undertaken in both oral and written complaints was the assistance provided by the MHCC for the local resolution of the complaint (42 per cent) followed by the provision of an explanation or informationt (39 per cent).

Due to the limitations in the data on the range of outcomes and actions recorded in our case management system, we undertook a thematic analysis of the actions and outcomes of the written complaints⁸ in order to provide a clearer picture of the ways in which the issues in complaints were addressed and resolved through our processes.

⁸ Detailed analysis was undertaken on 74 of the 87 'in-scope' complaints, representing 85 per cent of these complaints. Some complaints were excluded because of limitations in data recording for these complaints.

When the outcomes of these complaints were categorised into the 'Four A's' of complaint resolution, 62 per cent recorded an action outcome, 35 per cent recorded acknowledgements by the service, 26 per cent resulted in answers or explanations to the issue raised and 16 per cent resulted in an apology from the service (**Figure 12**). Acknowledgements included processes which enabled the person's concerns to be heard and the impact of their experience acknowledged by the service, together with what should have occurred in the circumstances of the complaint. Apologies were most commonly provided with an acknowledgement by the service of the person's concerns and experience.

The most common types of actions included meetings arranged by services to respond to issues raised by the consumer, family member or carer (19 per cent), followed by a change or review of relevant policies, procedures or practices (12 per cent), staff training or supervision (12 per cent), and a change of practitioner or case manager (11 per cent).

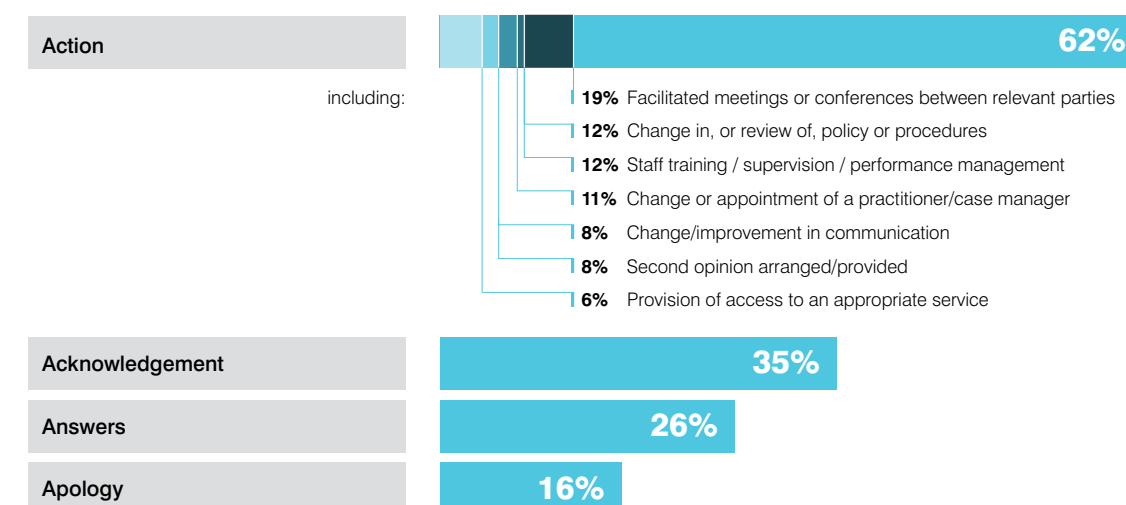
A broad range of other actions were taken including: access to an appropriate service from the provider, relocation or transfer to another service, provision of a second opinion, review or implementation of the consumer's treatment plan, change in medication, change in existing support arrangements, change or improvement to communication, discharge or termination of treatment, and provision of a printed copy of the statement of rights.

We have been pleased with the way in which services have worked to provide effective acknowledgements, answers, actions and apologies as part of the complaint resolution processes, and their preparedness to explore new approaches to resolving complaints.

Figure 12

Ways complaints to MHCC were addressed/resolved

Sample of closed complaints, n=74



Example complaint

Please note: The person's name has been changed and some details omitted to protect the identity of those involved.

IMPROVING SERVICE RESPONSES TO CONSUMERS

When working with consumers and services to resolve complaints, the MHCC looks at ways in which the complaint can lead to improved outcomes and improved services for the individual and for others in similar circumstances.

'Michelle' made a complaint about her experience with a mental health team in a hospital emergency department. Michelle's concerns included her feeling that the clinician was dismissive of her suicidal feelings and presumed that her partner could care for her without the need for a hospital admission. Because of the stigma she felt through this experience, Michelle felt reluctant to access the emergency department, and was concerned about what this would mean for her care.

Through our dealing with this complaint, Michelle was supported to meet with the service who responded in a way that made her feel heard and reassured her that her concerns were treated seriously. The service undertook to address the issues with the individual clinician, as well as ensuring that staff were reminded about the appropriate guidelines. The service also sought to restore Michelle's confidence in the service by offering to help her prepare an advance statement to guide and improve any future experiences in the emergency department. These agreed actions were confirmed with the MHCC, and Michelle felt that her complaint had resulted in a positive outcome for herself and for others.

Michelle also felt confident to return to the emergency department if needed in the future.

Our priorities

We are working to further develop our approaches to improve the timeliness and effectiveness of our resolution processes. We look forward to the implementation of our new case management system which will both support these processes and enable more detailed analysis of the resolution actions taken at different stages of complaint handling, from early resolution through to addressing issues in complex complaints. Our practice development will also be informed by ongoing feedback and evaluation.



06

**Increasing
knowledge
and oversight
through
complaint
reporting by
services**

Complaints reported by services for period 1 July – 31 December 2014

A cautionary note

Given issues identified in data gaps and the variability of data categories, it is difficult to draw conclusions from the statistics and themes identified in the following analysis of these initial reports. Caution should therefore be used in interpreting the results as being representative of all complaints recorded over the six month period.

Caution should also be used in drawing conclusions from relative numbers of complaints reported by services. Higher numbers of complaints reported by services can represent effective complaint reporting and/or a positive complaints culture. It might also demonstrate high numbers of issues experienced by people. Alternatively, low numbers of complaints may indicate a range of factors, including issues with the recording of complaints, the service's approach to complaints, or the level of satisfaction with the service.

One of the challenges we face is the need to develop a common understanding and approach to identifying and recording complaints, particularly those complaints that are resolved through direct responses by staff. This preliminary data analysis provides a window into some of the issues and themes that will benefit from further exploration and collaboration with services as we develop the next stages of reporting and analysis.

Overview

Thirty-five mental health services reported a total of 736 complaints received over the period of 1 July to 31 December 2014 (**Figure 13**). These services included 18 designated mental health services (DMHSs) and 17 mental health community support services (MHCSSs.) Thirty-one of these services recorded at least one complaint, while four MHCSSs provided a 'NIL return', indicating no complaints were recorded over the period. Of the total number of complaints across all services, 87 per cent were from DMHSs and 13 per cent were from MHCSSs. Services received an average of 21 complaints over the period, with the average for DMHSs (35.7 complaints) over six times higher than the average for MHCSSs (5.5 complaints).

It is likely that the total number of 736 complaints reported by services represents an under-reporting of complaints made directly to designated mental health services. This number of complaints is almost the same as the number of enquiries and complaints made to the MHCC in the same period, and represents only one to two per cent of all registered mental health clients in Victoria for 2014/15 (approximately 64,000).⁹

It is also worth noting that the proportion of complaints reported by MHCSSs is significantly different to the proportion of complaints made directly to the MHCC about MHCSSs (two per cent). This could be indicative of differences in the nature of complaints, effective local resolution of complaints by MHCSSs or the need to increase awareness of the MHCC among MHCSS consumers.

In analysing future reports, we aim to compare the relative proportions of complaints reported by services and complaints made to the MHCC across different service types with data on numbers of people treated and other service usage data. This will enable us to start identifying trends that may warrant further exploration.

⁹ Interim 2014/15 figures provided by Department of Health and Human Services, as available at 10 July 2015

Service types

Sixty three per cent of complaints reported to the MHCC were about adult mental health services, by far the largest coverage of any of the service programs. Other programs accounted for less than 15 per cent of complaints each (**Figure 14**).

Fifty-eight per cent of complaints where service type was recorded were made about inpatient services and 42 per cent were about community services (**Figure 15**). In most cases, providers did not record any further detail about the specific inpatient or community service to which the complaint related.

Most complaints recorded for adult services (63 per cent) and Child and Youth Mental Health Services (CYMHS) (76 per cent) were about inpatient services. All MHCSS complaints were identified as being about community services, but it is possible that some of these complaints were about residential services operated by these organisations, such as adult or youth residential rehabilitation services.

Figure 13

Number and types of complaints lodged with specific service providers

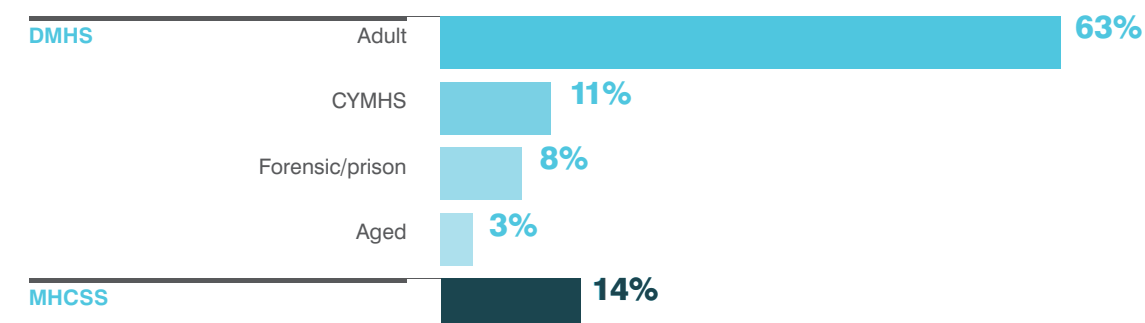
Base: All complaints, n=736

	Total	DMHS	MHCSS
Total number of providers	35	18	17
Number of providers reporting at least one complaint	31	18	13
Number of providers submitting a 'NIL return' (no complaints for the period)	4	0	4
Total number of complaints reported	736	643	93
Average number of complaints per provider	21.0	35.7	5.5

Figure 14

Service type subject to the complaint*

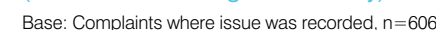
Base: Complaints where service type was recorded, n=650



“There has been a need to change the culture around complaints. This has happened, through regular data capture, meaningful accountability and a change in local views about the role of complaints and the relationship with consumers/patients.”

– Service provider

Base: Complaints where service setting type was recorded. n=650



Issues concerning environment, personal safety and facility management most commonly related to dissatisfaction with the physical environment of the facility (eight per cent). Other common concerns included consumers' property being lost, damaged or handled without permission (three per cent), concerns about an unsafe environment at the facility (three per cent) and alleged abuse, assault, intimidation or bullying by another consumer (two per cent each). The five per cent of 'other' complaints in this category included concerns about the appropriateness of the food provided and smoking-related issues. Examples included:

"Consumer raised concerns about bathroom not cleaned over weekend, pain relief not enough, not getting it on time....."

"This is a letter from all the patients – to have music, games, movies, charades & heating. Some would appreciate [staff] to be more patient with us and change bed sheets, different food."

The themes identified in this service data broadly reflect those identified in complaints made to the MHCC, with the exception of communication, which was recorded in only 11 per cent of local complaints. The themes about staff behaviour, treatment and environment/safety issues indicate specific concerns that warrant attention and action to improve these aspects of people's experiences and service provision.

While communication issues can be implied in some of the issues raised about staff behaviour and treatment, it is worth noting that communication issues are not explicitly identified in a higher proportion of complaints. In our discussions with services about the types of complaints received, communication was commonly identified as a primary or underlying issue in many complaints. It will be important to find ways for services to capture and record the types of communication issues raised in complaints in order to use this information to inform practice improvement and priorities for staff training and development.

Outcomes

The data indicated that a complaint outcome was recorded in 158 of the 736 complaints reported (21 per cent). Before we can draw any further conclusions on this, we need to develop a more detailed understanding of the data frameworks, in particular, whether there is an issue accessing this data through the VHIMS system, or whether this is indicative of a broader issue. This is an area of significant importance, given both the legislative requirement for services to report outcomes and the importance of this data to inform service improvements.

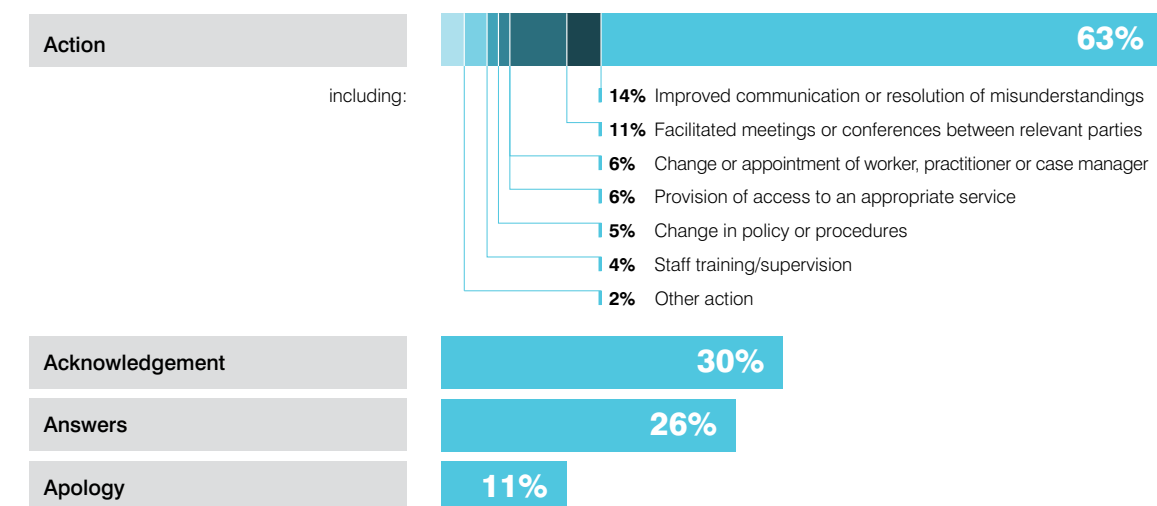
When the outcomes are recast into the 'Four A's' of complaint resolution categories (Acknowledgement, Answers, Action and Apology) a form of acknowledgement was reported for 30 per cent of complaints and answers (or explanation) in 26 per cent of complaints (**Figure 17**). In 63 per cent of cases, the outcome was some form of action, most commonly improved communication or resolution of misunderstandings (14 per cent), or facilitating meetings or conferences between relevant parties (11 per cent). Eleven per cent of complaints involved an apology.

- From MHCC vox pop video
available from: [mhcc.vic.gov.au/
video-voxpath.htm](http://mhcc.vic.gov.au/video-voxpath.htm)

A complaint is an opportunity to redress an issue that is causing distress or concern to a consumer.”

It means you have had a very unhappy experience of something and you've decided to do something about it."

Figure 17



Service improvements made as a result of complaints

Services were invited to report on any improvements that the service made as a result of complaints, as part of their outcome data. Limited examples were provided, with the most common being changes made to policies or procedures (eight complaints), followed by actions relating to staff training or supervision (six complaints).

The changes reported in policy or procedures were mainly in relation to the management of the environment of the facility, regarding cleaning and smoking policies or practices. Another example involved changes to appointment making practices to reduce the frequency with which changes occurred in appointment times.

The types of staff training provided as an outcome of issues identified in complaints included training on responses to assaults and incidents, supporting patients with reporting incidents to the police, approaches to discharge discussions with consumers and working with consumers with addiction issues.

As the majority of services have advised the MHCC that they report on themes in complaints as part of their internal quality improvement processes and reporting systems, we would expect more examples of service improvement outcomes from complaints. This will be a particular area for attention in our work with services on the development of reporting arrangements and tools.

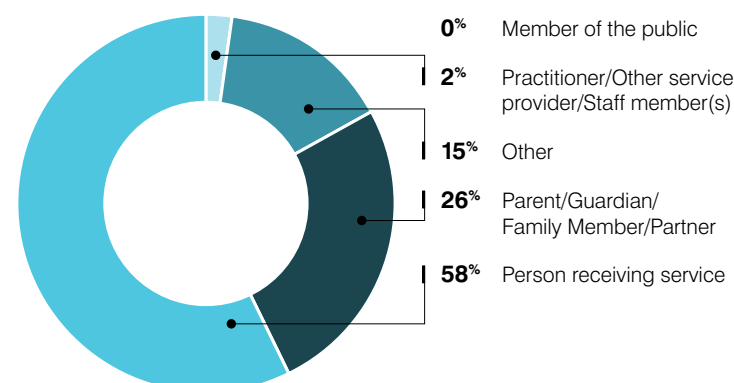
People who made complaints

Fifty eight per cent of complaints where the source of complaint was recorded were lodged by the person receiving the mental health service. A further 22 per cent of complaints were lodged by the consumer's parent, guardian, family member, or partner. There was no additional detail from services about the characteristics of the 15 per cent of complaints raised from the 'other' source (**Figure 18**).

Figure 18

Source of complaint

Base: Complaints where source was recorded, n=476



Fifty-two per cent of complaints related to female consumers, forty-seven per cent to male consumers, and one per cent related to transgender consumers. Fifty one per cent of complaints were made by women.

The cultural and linguistic background of people making complaints was recorded in less than half of all complaints (44 per cent, or 322 complaints). Of these cases, the majority of consumers were identified as being of 'Australian' ethnicity (94 per cent). We note the Australian Bureau of Statistics demographic data showing 28.1 per cent of Australians are born overseas and we will be working with services to promote the collection of consistent data on the cultural and linguistic background of consumers and people making complaints.¹⁰ This will help to gain an understanding of the extent to which complaint processes are supporting people from all cultural backgrounds and what work may need to be done to increase the accessibility of processes and build service capacity.

Our priorities

Over the next 12 months, we will work collaboratively with mental health services to build on the learning from this initial report, and develop reporting arrangements that ensure the complaints data collected from services has the rigour required for meaningful analysis that will support service and system improvements. We aim to develop a reporting tool which is user friendly and supports consistent interpretation of categories and response options. We will also be encouraging services to identify and share examples of policies and practices that have supported effective complaint resolution or have been improved as a result of a local complaint. This approach will enable both the MHCC and services to optimise the opportunity for increasing sector knowledge and service improvements that this key reporting requirement provides.

¹⁰ Australian Bureau of Statistics 3412.0 Released 29/01/2015

07

Promoting service and system improvements

Our role

Under Section 228 of the *Mental Health Act 2014* the Mental Health Complaints Commissioner has broad functions to provide advice on any matters arising out of complaints. We are specifically charged with identifying, analysing and reviewing quality, safety and other issues arising out of complaints to make recommendations for improving the provision of mental health services.

Our approach

During our first year we have promoted the way in which information from complaints can provide insights into people's experiences of services and be used to inform service and broader system improvements. Through our complaints' resolution work, we identified a number of policy and practice issues impacting on people's experiences within services, and discussed options for addressing these with services, the Chief Psychiatrist and the Department of Health and Human Services. We made a number of formal recommendations to services and to the department to review specific policies and practices for consistency with the Act, and to promote service improvements.

We also sought opportunities to share our knowledge and experiences in a wide range of forums and consultations relating to the Victorian mental health service system and to a number of national forums. Our participation in the activities outlined here also aimed to build our knowledge and connection with broader initiatives and discussions in mental health and related fields to inform our work and create opportunities to collaborate. As we build our evidence base and experience, we aim to undertake and contribute to strategic projects to advance service and system improvements that contribute to improved experiences for people accessing and receiving public mental health services.

Recommendations for review of policy and practice issues identified in complaints

In working to resolve complaints made to the MHCC, our objective is to look for opportunities to improve outcomes for individuals as well as opportunities to address broader policy or practice issues that are identified as underlying issues in complaints. We have been pleased that a number of services have responded to complaints we have raised with them by initiating internal reviews of policy, practice or systems issues and implementing service improvement actions. Initiatives include revised processes for recording the provision and explanation of the statement of rights to a consumer, and provision of staff training and reviewing supervision processes, including using complaints as a tool to support supervision for clinicians. As part of the resolution of complaints, we confirmed specific service improvement actions initiated by services as outcomes of complaints in more than 10 matters.

We have also worked with services on options to address issues identified in our assessment of complaints, and provided seven recommendations on particular areas of policy or practices that warrant review or consideration of actions to prevent a reoccurrence of the issue or incident. These issues have included policies related to access to mobile phones, laptops and other communication devices, systems to ensure that carers are notified of and consulted about key decisions, procedures to ensure that consumers' property is secured when emergency admissions are arranged by Crisis Assessment and Treatment Teams, access to second psychiatric opinions, and steps to ensure appropriate responses to incidents including support for consumers to report matters directly to the police. Some of these recommendations have directly highlighted the requirements of the Act and have sought to provide guidance to services in reviewing their policies and practices to ensure consistency with the new principles and requirements of the Act.

We also made a formal referral to the Department of Health and Human Services under s228(j) of the Act to review policy and practice guidance to the sector relating to access to mobile phones and other communication devices in acute inpatient units, fees charged in secure extended care units (SECUs), and the use of restrictive interventions in emergency departments. We have welcomed the opportunity to raise and discuss these emerging issues at regular meetings held with the Deputy Secretary, Mental Health, Wellbeing, Social Capital and Ageing; the Director of Mental Health Branch, Department of Health and Human Services (DHHS); and the Chief Psychiatrist. These issues have also been referred by agreement for further consideration by the department in its role of administering the Act and providing policy guidance to public mental health services. We will be providing further details of the specific issues and scenarios identified in complaints and contributing to the department's consideration of these matters.

Participation in Victorian sector consultations and forums

We have participated in a wide range of consultations and forums to contribute our knowledge and experience to date, as well as establishing connections across the mental health service sector to identify and respond to emerging themes and issues.

These consultations and forums included:

- bi-monthly meetings with departmental senior executives and the Chief Psychiatrist on emerging issues and sector developments
- meetings with Mental Health Senior Leaders groups for clinical services and for MHCSSs on themes identified in complaints
- meetings of the Consumer Partnership Dialogue Forum and the Carer Partnership Dialogue Forum (as an associate member)
- meetings with peak bodies such as VMIAC (Victorian Mental Illness Awareness Council), Tandem and VICSERV on emerging issues and developments
- regular liaison meetings with other statutory bodies such as the Mental Health Tribunal, Health Services Commissioner, Office of the Public Advocate, Australian Health Practitioner Regulation Agency (AHPRA), Victorian Ombudsman, Disability Services Commissioner and Victorian Equal Opportunity and Human Rights Commission (VEOHRC) to identify emerging issues and ensure effective referrals
- bi-monthly meetings of the 'Participation Advisory Committee – Doing it with us not for us', providing advice on a new participation policy for Victorian public health services including public mental health services
- meetings of the reference group for the new Independent Mental Health Advocacy Service operated by Victoria Legal Aid
- monthly meetings of the 'Open Minds' Board which works to decrease the stigma of mental illness for consumers and carers in the Victorian Public Service

We also provided input or submissions into:

- the Auditor-General's Draft Annual Plan for 2015–16
- the 'Internal Audit of Mental Health Legislative Reform Governance' conducted by KPMG for the department
- the 2015 Review of the *Charter of Human Rights and Responsibilities Act 2006*
- the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) annual report into the operations of the Charter
- preliminary discussions on input to the government's 10-year Mental Health Plan.



Consultations on the National Disability Insurance Scheme

Under the Act, the Mental Health Complaints Commissioner has jurisdiction to deal with complaints about services provided by publicly funded mental health community services. This includes services that are funded by National Disability Insurance Scheme (NDIS) that fall within the broad definition of a mental health community support service. As the role of the MHCC is unique in the NDIS trial sites, we have actively contributed to the considerations at both a state and national level about issues relating to access, quality and safeguards for the full roll-out of the scheme. NDIS related consultations and contributions included:

- attendance at the consumer forum on experiences with NDIS in the Barwon trial site
- participation in the national conference on ‘NDIS and Mental Health’ in October 2014
- participation in consultations on the draft Quality and Safeguards Framework convened by the department, the Disability Services Commissioners Group and VICSERV
- submission to the National Disability Insurance Scheme Quality and Safeguards framework.

Example complaint

Please note: Names and some details have been omitted to protect the identity of those involved.

ADVANCE STATEMENTS AND POLICY DEVELOPMENT AS PART OF COMPLAINT RESOLUTION

In working with the MHCC to resolve a complaint about the way a service had handled arrangements for a young child to visit his mother in an inpatient unit, the service offered to work with the consumer and her partner to include an advance statement on requested arrangements for any future visits, as well as placing an alert on the consumer's file. The option of the consumer officially nominating her partner as her 'nominated person' under the Act was also discussed as another way of facilitating optimal communication and consideration of wishes and preferences for visits. The service also identified the need to develop more detailed policy guidance for staff for arranging such visits to ensure consistency with the principles of the Act, including promoting the best possible therapeutic outcome for the consumer and the best interests of the child.

Participation in national mental health forums and consultations

We have also participated in national mental health forums and consultations to ensure our approaches are informed by issues and developments in public mental health in other jurisdictions and nationally, and to identify opportunities to collaborate and contribute to work aiming at improving people's experiences of mental health services and supporting recovery.

These national mental health forums and consultations included:

- participation in the Mental Health Leaders meeting in Brisbane with Mental Health Commissioners from Queensland, NSW, WA and New Zealand, and CEO of the National Mental Health Commission
- meetings with NSW Mental Health Commission about opportunities for collaborative work on research and projects to inform systemic improvements
- consultation with the National Children's Commissioner on findings from the *Children's Rights Report 2014* relating to intentional self-harm and suicide risk in people under 18 years of age, and young people's experiences accessing mental health services
- meeting with Mental Health Australia to discuss opportunities to consult on research and future projects
- briefings on the National Mental Health Commission's *Review of Mental Health Programmes and Services*
- participation in the 10th National Seclusion and Restraint Reduction Forum.

Participation in disability and health services commissioners' meetings

We have sought to collaborate and learn from other Australasian statutory complaint bodies such as Health Services Commissioners and the Disability Services Commissioners. We have contributed to various national consultations convened through these groups, including reviews of standards and regulation for health services and practitioners, and matters relating to the NDIS. Our activities included:

- participation in meetings of the health services commissioners' group to address common issues across jurisdictions, including approaches to complaints about mental health services
- participation in national meeting of representatives of Australian Health Practitioner Regulation Agency (AHPRA), health practitioner boards and health complaint bodies to review existing referral processes and protocols for dealing with complaints about individual health practitioners
- attendance at meetings of the Disability Services Commissioners to discuss approaches to complaints about NDIS funded supports and considerations for future quality and safeguarding mechanisms for the roll out of the full scheme.

Contributions to projects on Australian Safety and Quality Standards in Health Care

We contributed to relevant projects and reviews of quality and safety standards by the Australian Commission on Safety and Quality in Health Care (ACSQHC), identifying particular considerations for the application of these standards to the provision of mental health services.

We provided input into projects and workshops on:

- medication safety in mental health services
- review of ‘Standard 2 – Partnering with Consumers’
- the development of tools for shared decision making in health services, including mental health services.

We have also discussed opportunities to provide input into ACSQHC's project on guidelines for responding to clinical deterioration in mental health services, and their review of standards and guidance relating to complaint handling and open disclosure.

Contributions to development of standards and training for complaint handling and conciliation

We also took an active part in opportunities to contribute to the development and strengthening of standards and training in complaint handling and resolution, including formal dispute resolution processes such as conciliation. We have sought to promote relevant ongoing training and accreditation for our work, and to contribute to the development of approaches which promote access and participation for people experiencing mental illness. Our contributions have included:

- input into the project on developing 'Professional Standards in Complaint Handling' being undertaken by the Australian Centre for Justice Innovation at Monash University
- participation in the LEADR Statutory alternative dispute resolution (ADR) Special Interest Group on the development of relevant training and professional development for officers working in statutory complaints' bodies
- consultation with the Chair of the National Mediator Standards Board on the application of standards for conciliation and other dispute resolution processes conducted by the MHCC and similar statutory bodies.

08

Learning and growing our capability

“

I came into this office at the very start very passionate about it and excited about what the office stands for and generally where the mental health sector is going. The fact that we have an established mental complaints' body such as this Commissioner here makes me feel that the sector as a whole is really changing. I still hold that excitement today.”

– MHCC staff member

“

‘I have contacted the MHCC today for the first time, and must say I was pleasantly surprised by the genuine and considerate communication. As a service provider, I rang on behalf of my client. After my initial treatment I feel very confident passing the MHCC number to my clients. As a mental health carer myself, I may also need to utilise the service in future. I feel confident they would provide a good service.’

– Consumer/Carer

Our approach

As a new organisation working under a new Mental Health Act, we have made a significant investment in honing our expertise and in learning about the experiences of consumers, families, carers and Victorian public mental health services.

We have involved consumer and carer representatives on our recruitment panels and built a skilled and diverse team. Our team brings together people with lived experiences as consumers, family members or carers, as well as experiences in a range of roles and settings in the mental health system.

To build on this experience and expertise, we have undertaken a broad range of professional development, including comprehensive training on complaint resolution, the new Act, recovery-oriented practice, and the Victorian mental health sector. Resolution and Review team members have completed accredited training under the National Mediator Accreditation System.

We've ensured that the perspectives and experiences of consumers, families and carers, as well as specialist knowledge and clinical expertise in mental health treatment and best practice inform our learning and development.

We have also turned our attention to our own compliance, providing staff training and guidance about our legislative responsibilities, including the requirements of the *Victorian Charter of Human Rights and Responsibilities Act 2006* and privacy legislation.

We actively seek feedback from people who interact with our service so that we can continuously learn and improve. All our communication channels (including brochures, social media, and posters) feature our info@mhcc.gov.au email address. We have developed our own internal complaint policy and process to ensure that we respond to any concerns individuals may raise. We use this complaint information to improve our practices and systems. Our feedback processes encourage people to tell us about any aspect of their experience with us and our 'feedback tree' is displayed in our entrance area for all to read. Whenever we engage with our stakeholders, we seek feedback.

Our team members also participate in regular reflective practice sessions to review work and consider and make improvements.

Our priorities

Strategic directions

We have developed draft strategic directions for the next four years of operation and outlined the broad strategies that will help us achieve them. These strategies respond to feedback raised by consumers, families, carers, services and other stakeholders during consultations held in the lead-up to and in our first year of operation. We will be seeking further feedback to ensure our strategic directions respond to the issues and priorities identified by consumers, families, carers, services and other stakeholders.

Our vision is a public mental health system that welcomes and learns from complaints, and makes quality and safety improvements to protect the rights of consumers, families and carers and uphold the principles of the Mental Health Act in all aspects of service delivery.



Our vision is a public mental health system that welcomes and learns from complaints and makes quality and safety improvements to embed the rights of consumers, families and carers and uphold the principles of the Mental Health Act in all aspects of service delivery.

To make our vision a reality our strategic directions include four goals:

1. People are empowered – All consumers, families and carers are empowered to make a complaint or speak up.
2. Complaints are resolved locally – Victoria’s public mental health services respond to complaints in a way that supports people’s recovery and improves services.
3. Practice improves – We see measurable, positive change at a local service level and across the public mental health system.
4. Our capability grows – We are an effective organisation that achieves positive change through our influence in the mental health system.

How we will know we are succeeding

We will measure our success by:

- feedback from consumers, families and carers showing they are confident to make complaints directly with services and have achieved successful resolution by doing so
- the rate by which we meet agreed timelines for our complaint process
- the number of improved service outcomes identified as a result of complaints to our office
- feedback from people and services showing we upheld our principles in our work with them
- positive feedback and evidence from consumers, families, carers, services and stakeholders that demonstrate learning and practice change as a result of complaints
- evidence that services are proactively making undertakings or agreements to take specific actions to address concerns and provide confidence to people making complaints
- evidence that policy and decision makers have adopted our recommendations for system improvements.

Priorities for 2015–16

As a developing organisation, we are continuing to learn from the feedback we receive and evolve our approach and practices. Our strategic directions will guide our work over the next four years.

Our immediate priorities include:

- continuing to develop our internal processes to ensure we are working as effectively as possible, in particular that we respond to complaints in a timely way, particularly where there are issues of risk or safety
- implementing a new case management system to support our approach, capture better information for analysis and enable improved reporting
- developing a complaints’ reporting system for services to effectively report on the complaints made to their service and to strengthen the way we can support services to drive system-wide change
- working with services to improve complaints’ resolution practices, policies and procedures
- developing our education and engagement program
- establishing mechanisms for ongoing input and feedback to inform our work.

As part of our key priorities for 2015-16, we are establishing an MHCC partnership forum to provide a dedicated and ready way of shaping and collaborating on our work program and seeking advice, input and feedback. In doing so, we acknowledge the importance of maintaining strong engagement with all consumers, families, carers and services.

Finances

The Department of Health and Human Services (DHHS) provides financial services to the Mental Health Complaints Commissioner (MHCC).

The financial operations of the MHCC are consolidated into those of DHHS and are audited as part of the DHHS accounts by the Victorian Auditor-General’s Office. A complete financial report is therefore not provided in this annual report.

A financial summary of expenditure for 2014-15 is provided below.

Income	
Base budget	\$2,437,000
Carry forward from 2013–14 for establishment activities	\$1,307,614
Total income	\$3,744,614
Expenses	
Salaries, contractors and associated costs	\$2,260,261
Other expenses	\$730,570
Total expenses	\$2,990,831
Income – expenses	\$753,783
Requested carry forward to 2015-16 to complete establishment activities	\$680,503
Operating surplus / (deficit)	\$73,280

Compliance and accountability

Privacy and Data Protection Act 2014 and Health Records Act 2001

The Mental Health Complaints Commissioner is subject to the *Privacy and Data Protection Act 2014* in relation to the collection and handling of ‘personal information’ about individuals. ‘Personal information’ is recorded information that can identify a living person.

The MHCC must also comply with the *Health Records Act 2001* when dealing with ‘health information’. This is information that can identify a person, including a person who has died, about the person’s physical, mental or psychological health, disability or genetic make-up.

The MHCC’s privacy policy explains how we deal with personal and health information, and is available on the MHCC’s website at mhcc.vic.gov.au

Freedom of Information Act 1982

Requests for access to documents held by the Mental Health Complaints Commissioner, or the correction of documents held by the MHCC, can be made under the *Freedom of Information Act 1982*.

Applications can be made in writing to the Mental Health Complaints Commissioner at 570 Bourke Street, Melbourne, 3000 or by email to PrivacyFOI@mhcc.vic.gov.au

Charter of Human Rights and Responsibilities Act 2006

The *Charter of Human Rights and Responsibilities Act 2006* sets out twenty fundamental human rights for all people in Victoria, including the right to be treated equally and to have our privacy respected.

The Mental Health Complaints Commissioner is a public authority under the Charter, and is required to act compatibly with the human rights in the Charter and to give proper consideration to Charter rights in dealing with enquiries and complaints.

Protected Disclosure Act 2012

Disclosures of improper conduct by the Mental Health Complaints Commissioner or its officers can be made verbally or in writing to:

Independent Broad-based Anti-corruption Commission
GPO Box 24234, Melbourne Victoria 3000
Phone: 1300 735 135; Fax: (03) 8635 6444; Email: submit@ibac.vic.gov.au

More information about the *Protected Disclosure Act 2012* is available from the Independent Broad-based Anti-corruption Commission website at ibac.vic.gov.au



Appendix 1: Consultations

The Mental Health Complaints Commissioner thanks all people living with mental illness, families, carers and services that generously shared their thoughts and experiences during the extensive community consultations undertaken by our establishment team.

Consumer and carer groups:

Victorian Mental Illness Awareness Council (VMIAAC)
Mental Health Carers Network (now known as Tandem)
VICSERV
Our Consumer Place
Centre for Psychiatric Nursing – University of Melbourne (Director & Consumer Academic)
Southern Health Consumer and Carer Relations Directorate
Hearing Voices Network (Vic Voices)
Victorian Transcultural Psychiatric Unit
Bendigo and District Aboriginal Cooperative
Gippsland and East Gippsland Aboriginal Cooperative
Action on Disabilities within Ethnic Communities (ADEC)
ADEC Carer Reference Group
Main Connection Consumer Group (Castlemaine)
Pahran Mission Consumer Group
SANE Australia
Golden City Support Services Consumer Group – Bendigo
Geelong Consumer Advisory Group
Echuca St Luke's Consumer and Carer Consultant Network Victoria
Loddon Mallee Mental Health Carers Network (Echuca)
Northern Area Mental Health Service Carer Action and Advisory Group
Mutual Support and Self-Help Network including GROW, ARAFEMI (now Mind), Eating Disorders, Perinatal Anxiety and Depression Australia (PaNDA), The Compassionate Friends, Anxiety Recovery Centre
Mental Health Legal Centre
Victoria Legal Aid
Office of the Public Advocate

Consumers were also consulted from services including Neami, Prahran Mission, Mind Australia, Creative Group, and SNAP. We also received consumer feedback at locations including Oakleigh, Frankston, and Bairnsdale.

Carers were consulted from regions including Loddon Mallee, the Mornington Peninsula, and from the inner south in Melbourne.

Service Providers:

Royal Melbourne Hospital
Forensicare – Thomas Embling Hospital
Alfred Health
Eastern Health
Melbourne Health
Austin Health
Barwon Health
Bendigo Health
La Trobe Regional Hospital
St Vincent's Hospital Melbourne
Victorian Transcultural Mental Health (VTMH)
Orygen Health
Monash Health (Aged) – Kingston
Victorian Aboriginal Health Service (VAHS)
Mental Illness Fellowship
Pahran Mission
Neami
Mind Australia (head office, Bendigo & Morwell)
ERMHA (Eastern Region Mental Health Association)
Mood Support Group, Geelong
SalvoConnect (formerly Kardinia), Geelong Pathways, Geelong
Karingal – Transcend, Geelong
St Luke's Anglicare, Bendigo
Head Space, Bendigo
Golden City Support Services, Bendigo
Echuca Community Mental Health
Bendigo Health Carer Support Services
SNAP (Gippsland) – Bairnsdale Prevention and Recovery Centre
Creative House, Traralgon

Appendix 2: Presentations

Consumers, families and carers: conferences, events and forums

Victorian Mental Illness Awareness Council (VMIAAC) Consumer Workforce and Mutual Support Days
Tandem Carer Forum: the new Mental Health Act
Caring Counts – Mental Health Forum for Families and Carers: Tandem
Consumer Partnership Forum (DHHS)
7th Rural Conference for Families and Carers of People with a Mental Illness: Bendigo
Balancing the Scales Carer forum – Peninsula Carer Council & Carers Victoria
Navigating the Mental Health System program – Carers Victoria
Action on Disability within Ethnic Communities (ADEC) Carer's Reference Group Meeting
South West Carer and Respite Services Network Forum
South West Regional Carers Conference: 'Waves of Change'
SNAP Consumer Forum, Gippsland
Carer Consultant Network Victoria
Launch of ADEC's 10th Annual ArtAbility Exhibition in Federation Square
Monash Health Mental Health Week Art Competition Award Ceremony

Mental health services: events and forums

Mental Health Clinical Leadership Forum – The new Mental Health Act
Mental Health Act Implementation Project Officers Forum
Clinical Leaders Forum (DHHS)
Senior Leaders Forum for MHCSSs (DHHS)
Eastern Health Mental Health Service Academic Program
Peninsula Support Services Board and Staff Meeting
St Vincent's Mental Health Service Staff Forum
North East and Border Mental Health Service Executive and Staff
SNAP Gippsland Annual General Meeting

Mental health and health sector forums

Southern Metropolitan Mental Health Council (SMMHC) forum
Yarra Mental Health Alliance (YMHA)
Women's Mental Health Network: Annual General Meeting
Health Issues Centre Annual General Meeting
Northern Melbourne Medicare Local and Beyond Blue

National/International conferences

15th International Mental Health Conference
6th Australian Rural and Remote Mental Health Symposium National Mediation Conference 2014
Professional forums and conferences
Australia and New Zealand Association of Psychiatry, Psychology and Law (ANZAPPL) Winter Forum – Mental Health Act 2014
Australian Medical Association Victoria Mental Health Forum
15th Victorian Collaborative Psychiatric Nursing Conference
Australian Nursing and Midwifery Federation (ANMF) 23rd Annual Delegates Conference
Victorian Mental Health/Psychiatric Nursing Education and Professional Development Forum
Law Institute of Victoria 2015 Professional Development Program – Mental Health Act 2014
Victorian Association of Dispute Resolvers (VADR) Presentation
LEADR/IAMA Association of Dispute Resolvers Presentation
LEADR Statutory ADR Special Interest Group Presentation
Ethics & Alternative Dispute Resolution(ADR) Symposium, Latrobe University & Dispute Settlement Centre of Victoria

Other stakeholder forums

Victorian Department of Health Regional Directors
Dispute Settlement Centre of Victoria Staff and Mediator Forum
Community Visitors Regional Convenors Meeting
Justice Health Forum: 'Community of Care – a shared approach'
Australian Health Practitioner Regulation Agency (AHPRA) Medical Practitioners Board Meeting
Australian Health Practitioner Regulation Agency (AHPRA) Notifications Staff Forum
Inner South Community Sector Forum
Disability Justice Advocacy Service Meeting

Appendix 3: Service visits

Initial meetings and visits with services:

Albury Wodonga Health – North East and Border Mental Health Service
Alfred Health
Austin Health
Ballarat Health Services
Barwon Health
Bendigo Health Care Group
Eastern Health
Goulburn Valley Health
Latrobe Regional Hospital
Melbourne Health
Monash Health
Mildura Base Hospital
Mercy Public Hospitals Incorporated
North East and Border Mental Health Service
Peninsula Health
South West Healthcare
St Vincent's Hospital Melbourne
The Victorian Institute of Forensic Mental Health
The Royal Children's Hospital

Service site visits:

Alfred Health – Alma Road Community Care Unit (CCU)
Alfred Health – Homeless Outreach Psychiatric Service
Alfred Health/Mental Illness Fellowship – Prevention and Recovery Care (PARC) South Yarra
Alfred Health – Psychiatry Intensive Care Inpatient
Alfred Health – St Kilda Road Clinic – Continuing Care
Alfred Health – Waiora Community Care Team
Mental Illness Fellowship 'Opening Doors' service (Adult Residential Rehabilitation Service)
Austin Health – Adolescent Inpatient Unit
Austin Health – Adult Acute Inpatient Unit
Austin Health – Brain Disorders Program (BDP)
Austin Health – Child Inpatient Unit
Austin Health/ Mind – Community Recovery Program (Adult Residential Rehabilitation Service)
Austin Health – Psychological Trauma Recovery Service
Ballarat Health Services – Adult Acute Inpatient Unit
Ballarat Health Services – Secure Extended Care Unit (SECU)
Barwon Health – Bellarine Adult Community Mental Health
Barwon Health – Community Rehabilitation Facility (CCU)
Barwon Health – Geelong West Community Mental Health Team
Barwon Health – Jigsaw Youth Mental Health Drugs and Alcohol Services
Barwon Health – McKellar Centre Aged Care
Barwon Health/Neami – Prevention & Recovery Care (PARC)
Barwon Health – Surfcoast Community Mental Health Service

Barwon Health – Swanston Centre – Aged Acute Admission Unit
Bendigo Health – Adult Acute Inpatient Unit
Bendigo Health/Mind – Prevention & Recovery Care (PARC)
Bendigo Health/Mind – Youth Prevention and Recovery Care (YPARC) Bendigo
Community Forensic Mental Health Service – Clifton Hill
Dame Phyllis Frost Centre – Forensicare – Ravenhall
Eastern Health – Canterbury Road Community Care Unit (CCU) Camberwell
Eastern Health – Community Care Unit (CCU) Maroondah – Ringwood East
Eastern Health/Mind – Linwood House Prevention and Recovery Care (PARC)
Eastern Health – Maroondah Hospital Adult Inpatient Unit
Eastern Health/Mind – Prevention and Recovery Care (PARC) – Ringwood East
Eastern Health – Upton House, Adult Inpatient Unit, Box Hill
Goulburn Health Area Mental Health Service
Haven Foundation – Haven South Yarra (Pahran Mission)
Latrobe Regional Hospital – Bairnsdale Community Mental Health Service
Latrobe Regional Hospital/Snap – Bairnsdale Prevention and Recovery Care (PARC)
Latrobe Regional Hospital – Community Residential Care Units Traralgon
Latrobe Regional Hospital – Flynn Unit, Adult Acute Inpatient Unit
Latrobe Regional Hospital – Macalister Unit, Aged Inpatient
Manifold Place Community Health
Mallee Family Care – Mental Health Community Support Service (MHCSS)
Melbourne Assessment Prison – Forensicare
Melbourne Health – Inner West AHMS/Cohealth – Arion Prevention and Recovery Care (PARC)
Melbourne Health – Inner West AMHS – Royal Melbourne John Cade Adult Acute Inpatient Unit
Melbourne Health – Inner West Area Mental Health Service – Waratah Clinic
Melbourne Health – Mid West AHMS – Adult Acute Inpatient Unit (IPU)
Melbourne Health – Mid West AHMS – Aged Psychiatry
Melbourne Health – Mid West AHMS – Area Mental Health Rehabilitation Unit
Melbourne Health – Mid West AHMS – Harvester Clinic Community Team
Melbourne Health – Midwest Health – St Albans Community Care Unit (CCU)
Melbourne Health – North West AHMS Broadmeadows Community Care Unit (CCU)
Melbourne Health - North West Area Mental Health Service – Broadmeadows Hospital Acute Inpatient Service
Melbourne Health – Northern AHMS – Northern Hospital Epping – Inpatients Unit
Melbourne Health – Northern AMHS/Neami Northern Prevention and Recovery Care (PARC) Service – Preston



Appendices

Melbourne Health – Northern AMHS – Northern Community Care Unit
Melbourne Health – Orygen Youth Health – Continuing Care Team (CCT) – Sunshine
Melbourne Health – Orygen Youth Health – Inpatient Unit – Footscray
Melbourne Health – Orygen Youth Health – Parkville
Melbourne Health/Mind – Prevention and Recovery Care (PARC) Broadmeadows
Melbourne Health – South West Burnside Prevention and Recovery Care (PARC) with Cohealth
Mercy Mental Health Saltwater Clinic – Footscray
Mercy Werribee Community Care Unit
Mercy Werribee Psychiatric Unit
Mildura Base Hospital – Inpatient Unit
Mind Wangaratta – Mental Health Community Support Service (MHCSS)
Monash Aged Psychiatry – Allambee Nursing Home
Monash Aged Psychiatry – Kingston Hospital Aged Psychiatry
Monash Health/ERMHA – Prevention and Recovery Care (PARC) Clayton
Monash Health – Clayton Inpatient ‘P Block’ Unit
Monash Health – Casey Hospital Inpatient Unit
Monash Health – Dandenong Inpatient Units
Monash Health/Mind – Dandenong Youth Prevention and Recovery Care (YPARC)
Monash Health – Doveton Community Care Unit (CCU)
Monash Health – Middle South Community Care Unit (CCU) East Bentleigh
Monash Health/Mind – Narre Warren Adult Prevention and Recovery Care (APARC)
Monash Health – Narre Warren Extended Prevention and Recovery Centre (EPARC) with Mind
Monash Health/Neami – Noble Park Youth Residents Rehabilitations (YRR)
Monash Health – Peri Natal Unit
Monash Health/ERMHA – Prevention and Recovery Care (PARC) Clayton
Monash Health/ERMHA – Prevention and Recovery Care (PARC) Springvale – women only
Monash Health – Stepping Stone – Child and Youth Mental Health Service (CYMHS) Inpatient Unit

Neami Thomastown – Northern Housing Pathways Program
North East and Border Mental Health Wangaratta – Kerferd Inpatient Unit
North East and Border Mental Health Service/ Life Without Barriers – Jarrah Retreat Prevention and Recovery Care (PARC)
Peninsula Health – Adult Acute Inpatient Unit
Peninsula Health – Adult Prevention and Recovery Care (PARC) Frankston
Peninsula Health – Frankston Community Care Unit (CCU)
Peninsula Health/Mind – Youth Prevention and Recovery Care Youth Prevention and Recovery Care (YPARC)
Port Philip Prison – St Paul’s Psycho-Social Unit – Forensicare
Prahran Mission
Royal Children’s Hospital – Banksia Ward
Sale Community Health Centre
South West Health Care Acute Inpatient Unit
South West Healthcare – Camperdown Hospital
South West Healthcare – Camperdown Mental Health Service
South West Healthcare Extended Care Unit
St Luke’s Anglicare, Eaglehawk
St Vincent’s/Mental Illness Fellowship – Prevention and Recovery Care (PARC) Fitzroy
St Vincent’s Hospital – Aged Psychiatry
St Vincent’s Hospital – Body Image Eating Disorders Treatment & Recovery Service (BERTS)
St Vincent’s Hospital Melbourne – Acute Inpatient Service
St Vincent’s Hospital Melbourne – Footbridge Community Care Unit
Thomas Embling Hospital – Forensicare
Wimmera Uniting Care MHCSS – Ballarat

During interstate visits to attend meetings and conferences, the Commissioner also visited services in New South Wales and Queensland to see examples of new and innovative approaches to designing inpatient units for adults, children and young people:

Caboolture Hospital Acute Adult Inpatient Unit, Queensland
Lady Cilento Children’s Hospital, Children’s and Adolescent Inpatient Units, Brisbane
Marie Bashir Centre, Royal Prince Alfred Hospital, Sydney

call **1800 246 054**
free call from landlines
mhcc.vic.gov.au/form
help@mhcc.vic.gov.au

Mental Health Complaints Commissioner
Level 26, 570 Bourke Street
Melbourne Victoria 3000
T 03 9032 3328 F 03 9949 1506



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