

*Safeguarding rights,
resolving complaints
and improving services*

**Mental Health
Complaints
Commissioner**

Annual Report
2015–16



26 August 2016

The Hon. 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 2015–16.

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 these complaints, and our education activities.

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

Yours sincerely

Lynne Coulson Barr
Mental Health Complaints Commissioner

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Commissioner's message

For people experiencing mental ill health, their experiences can involve significant trauma and challenges. Their interactions with public mental health services may at times involve the loss of liberty and concerns about whether their rights have been upheld. For families and carers, there can often be considerable stress and anxiety about their loved one's wellbeing and safety.



Many people who contact our office can be experiencing high levels of distress and need a supportive process that helps them to clarify their issues and explore available options to address their concerns. The Mental Health Complaints Commissioner (MHCC) was established to provide accessible, tailored and responsive complaints processes for addressing the issues experienced by consumers, families and carers accessing public mental health services. The MHCC is a key component of the increased safeguarding, oversight and service improvement provisions introduced under the *Mental Health Act 2014* (the Act).

In 2015–16, we received in excess of 1,700 new enquiries and complaints, which is a 19 per cent increase on the number received in our first year of operation. This level of engagement, particularly by consumers, demonstrates the need for an independent, specialist complaints body that deals with concerns about public mental health services. It also strongly supports Victoria's decision to create the first statutory body of this kind in Australia.

The varied and often complex issues raised with our office reinforce our overriding responsibility to assess every complaint in light of the requirements and the principles of the Act, with a focus on safeguarding people's rights and resolving complaints in ways that support their recovery. The types of issues raised in complaints often relate to treatment, communication and staff behaviour and attitudes. This indicates the need for services to focus on ways in which the principles of the Act, particularly supported decision making and recovery-oriented practice, can be embedded into all aspects of treatment and care.

We have been pleased to see an increase in the number of service improvement actions taken as a result of people making a complaint. In 2015–16, 73 improvement actions were initiated by services through working with us to resolve complaints. We have used our legislative powers to make 53 recommendations to services to address policy, quality and safety issues, as identified in complaints raised with our office. A number of these recommendations resulted from two formal investigations, which addressed specific issues relating to risk assessment, and responses to allegations and adverse events. Alongside this work, we made four formal recommendations to the Secretary of the Department of Health and Human Services (DHHS) to address systemic policy and practice issues identified in complaints. We are committed to working with DHHS to progress a number of initiatives in response to the recommendations we have made.

Our engagement with consumers, families and carers, and the types of complaints made to our office, tells us that we need to continue working with services to create a positive complaints culture – an environment where people feel supported and confident to raise their concerns directly with services. Our analysis of the data from complaints reporting by public mental health services indicates that our office is receiving a similar number of enquiries and complaints to the number of complaints made directly to services. Our goal is to see a much higher proportion of complaints raised directly with services as a result of people being able and confident to do so, and as a result of complaints being recognised, resolved and reported by services.

To build the capacity of services to achieve this goal, and to highlight the important role of complaints in safeguarding people's rights and promoting service improvements, we delivered 97 direct education and engagement activities in 2015–16. These included presentations at key conferences and events and MHCC training sessions. We also worked with consumers, carers and services on the development of a learning package about effective responses to complaints.

Over the past year, we continued to address barriers commonly experienced by consumers, families and carers in raising their concerns, and to promote new ways of thinking about complaints. We delivered a range of tailored education and engagement initiatives to promote accessibility and responsiveness to priority population groups, including Aboriginal people, people who identify as lesbian, gay, bisexual, transgender and intersex, members of culturally and linguistically diverse communities, young people, and people with disabilities. We sought to align this work with the objectives of *Victoria's 10-year mental health plan* and its goal to promote equitable access and safe and inclusive services for everyone. We also increased our reach through engaging in social media and distributing new information materials that promote people's right to speak up, and the role of complaints in improving services for all Victorians.

To maximise our capacity and effectiveness in responding to the volume and complexity of complaints made to our office, we reviewed and adjusted our organisational structure, improved our processes, and implemented new approaches, drawing on feedback from people engaged in our work.

Over the coming year, our work will continue to be guided by the *MHCC strategic directions 2015–19* and the *MHCC education and engagement plan 2015–17*, which aim to maximise the impact of our work. We also look forward to the commencement of the MHCC Advisory Council in August 2016, which will play an important role in furthering our knowledge and shaping our work.

In 2015–16, the MHCC has benefitted from the collective effort of many people who share our goals and support the work that we do. I thank the Hon. Martin Foley, Minister for Mental Health, for his valued support and firm commitment to the role of our office, and acknowledge the integral role of DHHS in achieving our shared goals. I also acknowledge the many people in consumer and carer organisations, and in public mental health services, for their willingness to work with us to effect positive change. We have seen many examples of services and their staff striving to make a difference through their work and responding to concerns raised by consumers, families and carers.

I give special thanks to the MHCC staff for their unwavering passion and energy, and their dedication to our important work. I also acknowledge our strong and constructive working relationships with the Health Services Commissioner, the many DHHS officers who support our operations, the Office of the Chief Psychiatrist, the Clinical and Executive Directors and managers of services, our colleagues in other statutory bodies and the many committed community members who have continued to support us as we grow and develop as an organisation.

This collective effort is essential to improving people's experiences, and to realising our vision of a public mental health system that safeguards people's rights, embeds recovery-oriented practice, and sees responding effectively to complaints as an integral part of people's treatment and care.

We look forward to continuing our work with others to achieve this vision and the Act's overall goal of consumers being at the centre of their treatment and care, and supported in their recovery.

Lynne Coulson Barr



Summary

Year at a glance

Enquiries and complaints

1729

new enquiries and complaints

271

matters dealt with at any one time (ave)

Service improvements

126

service improvements identified as outcomes of complaints

73

initiated by services

53

recommendations made by the MHCC

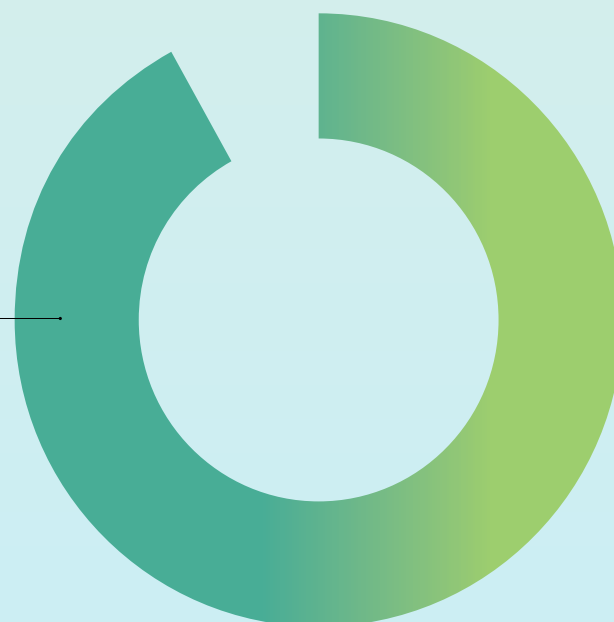
Complaint reporting from services

1640

complaints reported by public mental health services for 2015

92%

of services provided local complaint reports



Communications



14143

visits to our web site



2820

social media followers



14536

information products distributed

Education and engagement



2615

people involved in our education and engagement activities¹



97

direct education and engagement activities²



70

stakeholder engagement activities

System improvements and sector contributions



18

contributions to sector consultations, projects and submissions



4

formal recommendations to the Secretary of the Department of Health and Human Services on systemic policy and practice issues

1. Including consumers, families, carers, service staff and other stakeholders

2. Including presentations and training sessions



Summary

The Mental Health Complaints Commissioner's (MHCC) role and functions are determined by the *Mental Health Act 2014* (the Act). Our *Strategic directions 2015–19* sets out our vision and our goals, and guide the performance of our statutory functions. The following summary of activities highlights the progress we have made against these goals during the year.

GOAL 01 People are empowered

Our goal is for all consumers, families and carers to be empowered to make a complaint or speak up about their concerns.

In working to achieve this goal in 2015–16, we received 1,729 new enquiries and complaints, representing a 19 per cent increase on our first year of operation. We dealt with an average of 271 matters at any one time, and responded to 6,811 calls to our 1800 phone line.

Our team delivered 49 direct education and engagement activities to 696 consumers/carers, building the confidence of consumers, carers and families to make a complaint, and increasing their awareness of their rights under the Act.

We developed and delivered education and engagement initiatives to promote accessibility and responsiveness to priority population groups and align our work with the objectives of *Victoria's 10-year mental health plan*. These groups include Aboriginal people, people who identify as lesbian, gay, bisexual, transgender and intersex, members of culturally and linguistically diverse communities, young people, and people with disabilities.

Our team also developed a suite of engaging and targeted information materials conveying our key messages of 'It's your right to speak up' and 'Speaking up improves services for you and other people'. We continued our work to develop the new MHCC website, and increase our use of social media to ensure our online communication resonates with priority population groups and enhances our work in education and engagement.

GOAL 02 Complaints are resolved locally

Our goal is for Victoria's public mental health services to respond to complaints in ways that uphold people's rights, support their recovery and improve services.

In working to achieve this goal in 2015–16, we provided effective and timely responses to oral complaints, facilitating local resolution between the person and the service in 717 of 1,138 cases (63 per cent). We also identified 73 service improvements initiated by services as outcomes of complaints made to the MHCC.

We furthered our education and engagement with services, highlighting people's rights under the Act and the mental health principles, and how these apply to the provision of mental health services and the resolution of complaints. Our team delivered 29 presentations and education sessions to 1,077 staff in mental health services and across the sector.

We engaged consumers, carers and services on the development of an MHCC learning package, with the aim of building the capacity of service staff to provide effective responses to complaints, and support them in viewing complaints as an opportunity for improved outcomes for both the individual and the service.

For the 2015 calendar year, 92 per cent of public mental health services reported the number of complaints they received, and the outcomes of these complaints, to the MHCC. Our team also continued to work closely with DHHS on their Victorian Health Incident Management System improvement project, which aims to address the challenges faced by services in complaints reporting within the current system.

GOAL 03 Practice improves

Our goal is to see measurable, positive change at the local service level and across the public mental health system.

In working to achieve this goal in 2015–16, we made a number of recommendations to both services and DHHS to address issues and enable positive change.

We made 53 recommendations to services to address policy, quality and safety issues identified in complaints. These included detailed recommendations to services arising from two formal investigations completed in 2015–16.

We made four formal recommendations to the Secretary of DHHS to address systemic policy and practice issues relating to the categorisation and investigation of allegations of assaults in services, protocols with Victoria Police, and training for mental health staff on the needs of consumers with intellectual disability. These recommendations were noted by the Secretary and referred to DHHS for consideration.

We provided further advice to DHHS on the recommendations we made in 2014–15 regarding the use of restrictive interventions in emergency departments, a review of fees for secure extended care units and the development of policy guidelines regarding access to mobile phones and other communication devices in inpatient units.

We also worked with DHHS and the Disability Services Commissioner to ensure access to complaint processes and the safeguarding of the rights of people receiving NDIS-funded supports.

Our team delivered 15 presentations at conferences and forums on the role of complaints in safeguarding rights and promoting service improvements, contributed to 18 sector consultations, projects and submissions, and undertook 70 stakeholder engagement activities. These activities enabled us to strengthen working relationships, and identify opportunities for improving practice and addressing systemic issues.

GOAL 04 Our capability grows

Our goal is to be an effective organisation that achieves positive change through our influence in the mental health system.

In working to achieve this goal in 2015–16, we initiated the establishment of the MHCC Advisory Council, which will be an inclusive and diverse group of consumers, carers and people working in services who will inform our priorities and actions.

To maximise our capacity to meet increased demand, and support an integrated approach to our work in resolution, education and engagement, and strategic projects, we reviewed and adjusted our organisational structure. We also developed the *MHCC business plan 2015–19* and the *MHCC education and engagement plan 2015–17* to ensure we are well positioned to achieve what we set out to achieve, perform our statutory functions to the highest of standards, and increase the impact of our work.

We implemented a new case management system in 2015. Although this system is not yet fully functional, we are committed to improving the system in order for us to effectively capture and analyse our data.

We undertook a number of evaluation initiatives, including a pilot program seeking feedback from people who have made a complaint to our office. We will draw on the results of this program to build our understanding of what we are doing well and where we can improve. We also completed an internal audit assessing the cultural competence of our organisation, reflecting our commitment to providing a safe and responsive service for Aboriginal people.

In 2015–16, we undertook a range of learning and development activities to build the knowledge and capability of our team, including participation in various training programs and in regular reflective practice sessions.



About the Mental Health Complaints Commissioner

A NOTE ON LANGUAGE

We aim to use inclusive and person centred language, as guided by feedback from consumers, families, carers and services. We recognise the diversity of views and preferences in relation to terms such as consumers and patients. In most cases throughout this publication we have used the terms as they appear in the Mental Health Act 2014 (the Act). We also acknowledge that many people may support those receiving mental health services and refer to families and carers. We use the term 'services' to refer to public mental health service providers.

PUBLIC MENTAL HEALTH SERVICE MEANS:

Designated mental health services

Health services that may provide compulsory assessment and treatment to people under the Act. These services also provide treatment on a voluntary basis and include hospital based services, community residential and specialist and forensic services.

Publicly-funded mental health community support services

Community support services for people with a mental illness that are provided by non-government organisations and that are publicly funded.

Legislative background

The Mental Health Complaints Commissioner (MHCC) opened on 1 July 2014. Our office was established under the *Mental Health Act 2014* (the Act) as an independent body to provide an 'accessible, supportive and timely complaints mechanism that will be responsive to the needs of people with mental illness' (Second Reading Speech to Victorian Parliament, 2014).

A key objective of the Act is to protect the rights and dignity of people receiving mental health services, and place them at the centre of their treatment and care. The MHCC is an important component of the safeguard and oversight mechanisms of the Act that were introduced to ensure rights are protected and the mental health principles are upheld. Our office was established in response to community concerns about existing complaint processes, and the need for an independent body to ensure complaints lead to improvements in the safety and quality of mental health services.

Our functions

The Act gives the MHCC the following key functions (s 228) to:

- accept, assess, manage and investigate complaints relating to public mental health services
- endeavour to resolve complaints in a timely manner using formal and informal dispute resolution (including conciliation), as appropriate
- provide advice on any matter relating to a complaint
- make the procedure for making complaints in relation to services available and accessible, including publishing material about the complaint procedure
- provide information, education and advice to services about their responsibilities in managing complaints
- assist consumers and people acting on behalf of, or who have a genuine interest in the wellbeing of, consumers to resolve complaints directly with the service, either before or after the Commissioner accepts the complaint
- assist services in improving policies and procedures for resolving complaints
- identify, analyse and review quality, safety and other issues arising from 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. This includes National Disability Insurance Scheme (NDIS) funded psychosocial supports provided by mental health community support services. To strengthen oversight, the Act also introduced the requirement for all public mental health services to provide a biannual report to our office detailing the number of complaints they have received and the outcomes of these complaints.



Under the Act, we can accept complaints about a person's experience with a public mental health 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 enables us to accept complaints without the consumer's consent, if we are satisfied there are special circumstances and accepting the complaint will not be detrimental to the consumer's wellbeing. If we accept a complaint without the consumer's consent, the Act requires us to notify the consumer of this decision. We also seek to involve the consumer in the resolution of the complaint as early as possible, whenever possible, to uphold their rights and the mental health principles of the Act.

We are required to assess written complaints made to our office and make a decision to either formally accept or close the complaint within 20 business days of having received the complaint. To meet this timeframe, we make an early assessment that considers our jurisdiction, whether the consumer consents to the complaint, and whether it is appropriate for the MHCC to accept the complaint.

What we do

- We help people to speak up about their concerns by supporting them to make a complaint directly to their public mental health service or to us.
- We work to address people's concerns and complaints through informal and formal resolution approaches.
- We make recommendations for service and system improvements and use our investigation and compliance powers to effect change.
- We help Victorian public mental health services to develop accessible and responsive resolution approaches for addressing concerns and complaints.
- We receive and analyse reports from public mental health services about the complaints they receive and the outcomes of these complaints.
- We can also undertake investigations into any matter relating to Victoria's public mental health services, as requested by the Minister for Mental Health.
- We carry out these functions to safeguard people's rights and improve mental health services.

How we work

- We uphold the principles of the Act in all aspects of our work.
- We safeguard and promote people's rights and wellbeing.
- We aim to resolve complaints in ways that support people's recovery and improve services.
- We value the experience of consumers, families and carers and work collaboratively with them.
- We believe all experiences can contribute to improving services, and we work in partnership with public mental health services to support and effect positive changes.
- We work strategically to increase our reach and impact.

Our principles

Accessible

We are responsive and flexible, adapting our approaches to meet people's individual needs.

Supportive

We embrace diversity and do our best to help everyone who contacts us, listening with compassion, empathy and an open mind.

Accountable

We keep individuals and services informed about our actions and outcomes, our practices are consistent, and our decisions are fair, evidence based and transparent.

Collaborative

We work with consumers, families, carers and services, sharing what we learn and working together to effect positive change.

Learning focused

We always look for ways to learn and develop, asking people about their experience with us and drawing on their feedback to improve how we work.

Example complaint

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

Joshua raised his concerns with us about not being able to access culturally appropriate services as a consumer at his local community mental health service. Joshua explained to our resolutions officer that he had asked service staff for a male Aboriginal worker to be involved in his ongoing treatment and care. He told us that he felt his needs were not understood by his treating clinicians and that he was not comfortable discussing his mental health concerns with a female or non-Aboriginal worker. Joshua had a history of significant trauma and attempts of self-harm.

In Joshua's discussions with the service, the service manager explained that they did not currently employ a male Aboriginal worker and that it was not possible to meet his request.

In response to Joshua's complaint, we identified concerns about the service upholding the mental health principles of the *Mental Health Act 2014* that include the requirement for services to recognise the distinct culture and identity of Aboriginal people receiving mental health services.

We asked the service to consider other ways to meet Joshua's individual needs. We worked with both the service and Joshua to identify an Aboriginal worker in a neighbouring Aboriginal support service who Joshua felt comfortable with and who was available to assist in developing a recovery and support plan. We also provided advice to the service on the need for their approaches to be informed by guidelines and resources for providing culturally safe and responsive services.

The mental health principles

The Act introduced a set of mental health principles that services must uphold when providing mental health services. These principles must also be upheld by any person performing any duty or function under the Act, including the MHCC.

The Act sets out the following mental health principles (s 11(1)):

- (a) People receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred.
- (b) People receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life.
- (c) People receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected.
- (d) People receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.
- (e) People receiving mental health services should have their rights, dignity and autonomy respected and promoted.
- (f) People receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.
- (g) 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.
- (h) Aboriginal people receiving mental health services should have their distinct culture and identity recognised and responded to.
- (i) 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.
- (j) Children, young people and other dependents of people receiving mental health services should have their needs, wellbeing and safety recognised and protected.
- (k) Carers (including children) for people receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible.
- (l) Carers (including children) for people receiving mental health services should have their role recognised, respected and supported.

Complaints and recovery

Supporting a person's right to make a complaint, and their right to be heard and respected, are integral to recovery-oriented practice.

A key principle of the *Mental Health Act 2014* (the Act) is that 'persons receiving mental health services should be provided those services with the aim of bringing about the best possible outcomes and promoting recovery and full participation in community life'(s 11(b)).

Services are required to embed recovery-oriented practice into all aspects of the treatment and care that they provide, in accordance with the Act, the Victorian Framework for Recovery-oriented Practice (2011) and the National Framework for Recovery-oriented Practice in Mental Health Services (2013).

These frameworks recognise that there is no single definition or description of recovery. Our understanding is influenced by these frameworks, and by the perspectives of people with lived experience as consumers, families and carers. These perspectives offer insights into the unique experience, process and journey as defined and determined by each person in relation to their mental health and wellbeing.

Recovery-oriented practice puts the consumer at the centre of treatment and care. It involves an appreciation of the importance of consumers being actively involved in decision making about their treatment as reflected in the principles of supported decision making in the Act.

Complaints, particularly those about treatment, communication and staff attitudes, enable us to identify areas of service provision where greater attention is required to embed recovery-oriented practice.

By providing avenues for people to raise their concerns, to have their experiences heard and respected, and to be actively involved in the resolution process, complaints can play a vital role in improving people's experiences and supporting their journey towards recovery.

'Recovery is not the same thing as being cured. Recovery is a process not an end point or a destination. Recovery is an attitude, a way of approaching the day and facing the challenges. Being in recovery means recognizing limitations in order to see the limitless possibilities...'
– Deegan 1996

'Recovery involves living as well as possible.'
– South London and Maudsley NHS Foundation Trust 2010

'The aim of a recovery-oriented approach to mental health service delivery is to support people to build and maintain a (self-defined and self-determined) meaningful and satisfying life and personal identity, regardless of whether or not there are ongoing symptoms of mental illness.'
– Shepherd, Boardman and Slade 2008, quoted in The Victorian Framework for Recovery-oriented Practice 2011

'Recovery is... being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'.
– National Framework for Recovery-oriented Practice in Mental Health Services 2013

'In recovery-oriented practice there is a focus on the restoration of hope and dreams, the person's strengths, informed risk taking, use of positive language, self-determination and person centred practice. It requires a partnership approach, with the person experiencing mental ill-health being actively involved in guiding and selecting options for their treatment and support for their wellbeing. A focus on strengths and success is pivotal to the relationship that the professional has with the consumer.'
– Stratford et al. 2016





Safeguarding rights and resolving complaints



RISK AND SAFEGUARDING ISSUES

In complaints involving risk and safeguarding issues, our approach is informed by reviewing relevant documentation such as incident reports, clinical records, relevant policies and guidelines, and reports of investigations or incident reviews conducted by the service or external investigators. Practice is assessed against the National Standards for Mental Health Services, National Safety and Quality Health Service Standards and other relevant standards.

Safeguarding rights

The Mental Health Act 2014 (the Act) provides the legislative framework for the assessment of people who appear to have mental illness, and the treatment of those experiencing mental illness. In fulfilling our statutory functions, a key priority of the Mental Health Complaints Commissioner (MHCC) is safeguarding, protecting and promoting the rights of people who use public mental health services. Our work reflects our focus on ensuring compliance with the Act, and that the mental health principles are observed. In working to resolve complaints, we also give consideration to human rights principles, ensuring the consumer is front and centre of what we do.

All mental health services have a responsibility to safeguard the rights of people receiving treatment and care, especially in environments where people may be vulnerable. Examining safeguarding arrangements for consumers is a key component of our work in resolving complaints. It is essential that all service staff are aware of their obligations and responsibilities as outlined in the Act, and that services protect and promote people's rights and keep people in their care safe from harm.

We encourage consumers to speak up about their treatment and care, and expect services to take the extra steps that are needed to communicate effectively, to empower people to engage in dialogue with them, and to seek outcomes that improve the services they provide. Such approaches are also integral to embedding recovery-oriented practice and improving people's experiences in services.

We work with services, the Chief Psychiatrist, the Department of Health and Human Services (DHHS) and other relevant statutory bodies, sharing information about safeguarding to ensure services are safe for the people who use them. We draw on evidence from our analysis of issues relating to people's rights and safety, as identified in complaints, to emphasise the need to make strong safeguards an integral part of providing treatment and care in public mental health services.

Our approach

The Act gives the MHCC the flexibility to choose an individualised approach that is most appropriate for the specific complaint. Our options for dealing with complaints include:

- assisting people to raise their concerns directly with the service
- using informal and formal dispute resolution processes, including reviewing service responses, facilitating conferences, and seeking and confirming actions to address identified issues
- providing advice and recommendations to services
- referring the complaint for conciliation
- investigating matters, seeking formal undertakings from services and issuing compliance notices, where appropriate.

We assess every complaint with reference to the rights and requirements established in the Act, with a particular focus on the mental health principles. We work to resolve complaints in ways that:

- **safeguard rights**, promoting awareness of people's rights and compliance with the Act and the *Victorian Charter of Human Rights and Responsibilities Act 2006*
- **support recovery**, ensuring people feel heard and respected and are confident that their concerns have been taken seriously and that their views and preferences have been appropriately considered
- **improve services**, ensuring compliance with the requirements of the Act and the mental health principles and identifying opportunities to improve services



- **improve individual experiences**, providing a person centred process that works to reduce fears and build the confidence and relationships needed for a person to raise complaints directly with the service
- **aim to prevent a recurrence of issues**, for the individual concerned or for others.

Wherever possible, we promote the early resolution of complaints between the person and the service. We support the person and the service to work together to gain a mutual understanding of the issues and reach agreement on ways in which these can be addressed and resolved.

In resolving complaints, we are guided by our principles and informed by recovery-oriented approaches, alternative dispute resolution theory, best practice approaches in complaint handling and investigations, and ongoing feedback from those involved in our processes.

We work with services to develop ways to effectively respond to complaints, and to take into account the 'Four As' of complaint resolution: acknowledgement, answers, action and apology. We aim to ensure services implement any agreed actions to address individual concerns or improve the services they provide, and record these as outcomes of complaints. We also use our powers under the Act to obtain responses from services on risk and safeguarding issues, to investigate matters and provide recommendations to services for addressing quality and safety issues identified in complaints.

Enquiries and complaints to the MHCC in 2015–16 – Overview

In 2015–16, the MHCC received 1,729 new enquiries and complaints about Victorian public mental health services, comprising 340 enquiries (20 per cent) and 1,389 complaints (80 per cent), as shown in Figure 1.

Including the 273 complaints that were carried forward from 2014–15, we dealt with a total of 2,002 matters in 2015–16, consisting of 1,662 complaints and 340 enquiries.

We approach our work with consumers, carers, families and services with rigour to enable us to respond to enquiries and complaints and prioritise matters where issues of risk or safeguarding are identified. We understand that many people who contact our office are experiencing severe distress and other challenges. We aim to provide a sensitive and considered response, which often involves a number of discussions about the issues that people are seeking to raise.

In our second year of operation, we continued to see a high level of demand for our services. We work to balance the competing demands of providing timely responses to urgent matters, while also undertaking detailed assessments and resolution activities for the complex issues raised in many complaints. We continue to develop our practices and processes to meet the diverse needs of consumers, carers, families and services.

DEFINITION OF ENQUIRY

An enquiry is a request for information, advice or assistance. Enquiries to the MHCC can include requests for information about accessing services or how to make a complaint.

DEFINITION OF COMPLAINT

A complaint is an expression of dissatisfaction about a service for which a response or resolution is explicitly or implicitly expected from the MHCC or legally required (based on Australian Standard AS/NZS 10002:2014). Complaints can be made orally or in writing. To be formally accepted, they need to be made or confirmed in writing.

How we receive complaints

We receive complaints by phone, email, fax and letter, and via our website, private messages on social media, and face-to-face contacts. The majority of first contacts with our office are made via our 1800 phone line.

In 2015–16, 956 of 1,389 new complaints were dealt with as oral complaints (69 per cent), as shown in Figure 2. With much of our work in responding to complaints occurring over the phone, we have demonstrated our commitment to promoting the responsive and timely resolution of complaints.

The majority of oral complaints we work with relate to issues that are of immediate concern to the individual. This includes concerns about treatment and care during an inpatient admission, rights as a compulsory patient, imminent discharge planning, and concerns for the safety and wellbeing of consumers and carers.

While the legislation requires a complaint to be confirmed in writing in order to be formally accepted, many of the issues raised in oral complaints require a timely and immediate response by the service. As the legislation also provides for our office to assist a person in resolving their complaint directly with the service, we assess the urgency and gravity of the issues presented in oral complaints and facilitate a direct response from the service, where appropriate.

When responding to oral complaints, we seek to clarify the person's concerns and obtain their consent to contact the service in order to explore options for a direct response and early resolution. This often requires significant time and skill on the part of our resolutions officers who respond to callers in distress, assess complex issues, and identify risk and safeguarding issues. Responding to oral complaints often allows us to facilitate a prompt response from the service, which builds the person's confidence and strengthens their relationship with their treating team. We also accept and work to resolve complaints where an early resolution process is not possible or appropriate, and we provide assistance to confirm complaints in writing, where necessary.

Figure 2
how complaints were raised

base: all complaints raised with the MHCC
n = 1389

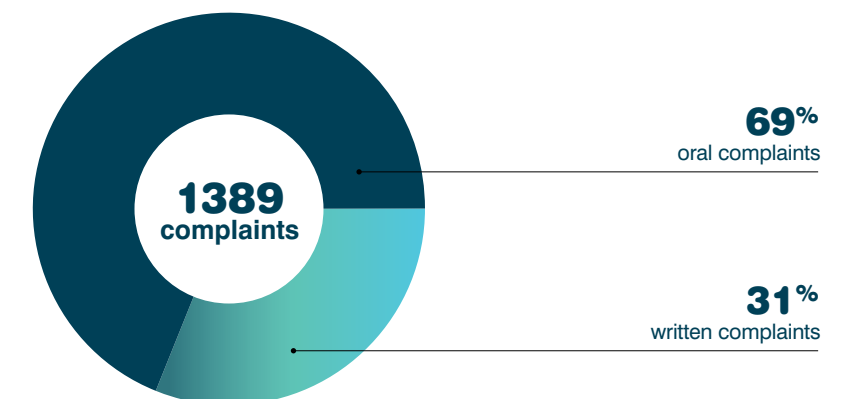


Figure 1
breakdown of enquiries and complaints to the MHCC





People who contacted us

Of the 1,729 new enquiries and complaints made to the MHCC in 2015–16, consumers raised 1,170 (68 per cent) and family members and carers raised 441 (26 per cent), as shown in Figure 3. The remainder were made by advocates, legal representatives, friends and other services or were referred from other bodies such as the Chief Psychiatrist, the Health Services Commissioner, the Australian Health Practitioner Regulation Agency, the Disability Services Commissioner, the Office of the Public Advocate and the Community Visitors Board.

We received more enquiries and complaints both from consumers and from families and carers than in 2014–15 (1,041 and 340 respectively). There was a slight change in the breakdown, with 71 per cent of enquiries and complaints made by consumers and 23 per cent made by families and carers in 2014–15 with the remaining six per cent raised by others.

When we receive complaints from family members and carers, we discuss the options that are appropriate for their situation, including:

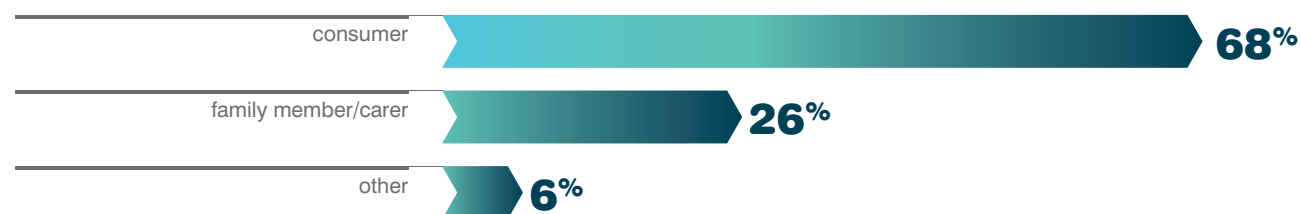
- assisting them to resolve their concerns directly with the service
- seeking the consent of the consumer for our office to accept the complaint
- considering if there are special circumstances that would allow us to accept the complaint without the consumer's consent, as permitted by the Act.

We seek to recognise and respect the important role of carers and families in raising issues on behalf of consumers, and work to involve the consumer in the resolution of the complaint as early as possible, whenever possible.

Given the nature of our engagement with those who contact our office, it is not always appropriate or possible to capture information on gender identity, age and cultural and linguistic background. We continue to work on ways of capturing this data and promoting the accessibility of our office to priority population groups, as demonstrated in the section about education and engagement (see page 45).

Figure 3
how cases were raised

base: all enquiries and complaints raised with the MHCC n = 1729

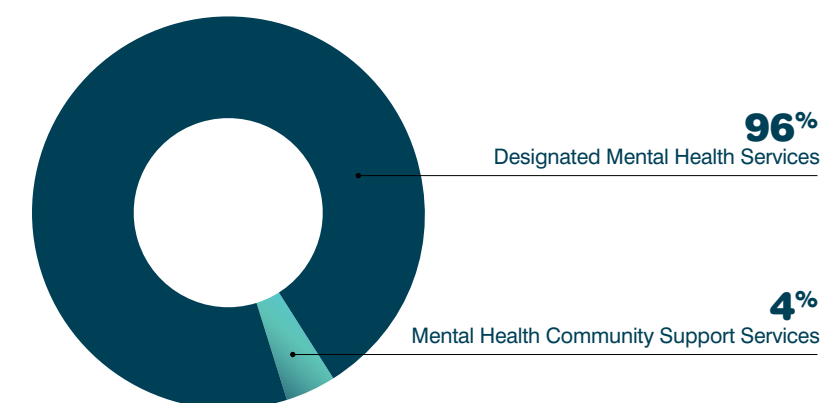


Type of service provider

The vast majority of new enquiries and complaints made to the MHCC (96 per cent) related to designated mental health services, with only four per cent relating to Mental Health Community Support Services (Figure 4). This breakdown is similar to 2014–15, where 97 per cent related to designated mental health services and three per cent related to Mental Health Community Support Services. The significantly higher proportion of complaints about designated mental health services may be explained by the higher numbers of consumers receiving treatment in designated mental health services, including compulsory treatment.

Figure 4
type of service provider

base: all enquiries and complaints raised with the MHCC where service provider was identified as either DMHS or MHCSS n = 1442





Service program types

Of the new enquiries and complaints made to our office, 82 per cent were about adult mental health services, five per cent were about forensic services (including services in prisons), five per cent were about aged mental health services, four per cent were about Mental Health Community Support Services, and four per cent were about Children and Youth Mental Health Services (CYMHS) or Child and Adolescent Mental Health Services (CAMHS), as shown in Figure 5.

Fifty-nine per cent of matters raised about adult services related to inpatient services (including secure extended care units and specialist inpatient services), 35 per cent related to community services (including community area mental health services or community care units) and the remaining six per cent related to other types of services.

Complaints about CYMHS or CAMHS services were almost equally divided between inpatient and community services.

While the number of complaints about aged mental health services was relatively small (67), the majority of these complaints were about inpatient services (76 per cent). There is some overlap in the jurisdiction between the new Aged Care Complaints Commissioner (ACCC) and the MHCC with respect to mental health services provided in nursing homes and aged care services. We are working with the ACCC to develop processes to ensure effective consultation and referrals between our offices.

The MHCC has jurisdiction to accept complaints from prisoners where services are provided by designated mental health services. Six per cent of all calls (431 of 6,811) to our office were made by prisoners on a dedicated phone line for responding to concerns about mental health treatment in prisons. The majority of calls represent immediate issues about access to treatment or particular medications, and are therefore dealt with as oral complaints requiring a facilitated response from the mental health service providing treatment within the prison.

Example complaint

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

Darren, a consumer who had been receiving mental health treatment in hospital for several years, contacted our office about wanting to live in the community. A member of our resolutions team spoke with Darren, together with his case manager, to discuss his concerns about the length of time he had been residing within the service.

In our initial discussions, the service manager explained that Darren had a cognitive impairment, and that the service had not been able to find accommodation and adequate supports that would meet Darren’s complex behaviour support and daily living needs.

We considered whether Darren’s treatment was least restrictive and in keeping with the principles of the *Mental Health Act 2014*. These principles include the requirement for services to provide treatment in ways that support the consumer’s recovery and full involvement in community life, while responding to their individual needs, including for disability support. We assessed that Darren’s complaint was about the adequacy of the service’s planning for him to receive less restrictive treatment and to be supported to live in the community.

We accepted the complaint and worked with the service and Darren to explore options for ensuring his treatment was provided in the least restrictive way possible. Our resolutions officer found that avenues for additional support had not been fully explored. We asked the service to further investigate support options through disability services, as well as to create a detailed transition plan that would enable Darren to live in the community.

The service pursued a re-assessment of Darren’s eligibility for disability supports and worked proactively with disability services to identify accommodation and additional supports that would meet his individual needs and complement the clinical support provided by the service.

As a result of the complaint, Darren, and the service now have a clear plan for his move into community supported living, and the service understands the actions they need to take to appropriately assess and respond to people’s disability support needs. When the NDIS is rolled out to Darren’s area, he is now well placed to receive NDIS funded disability supports.

Figure 5
service program types

base: all enquiries and complaints raised with the MHCC where service program was identified n = 1478



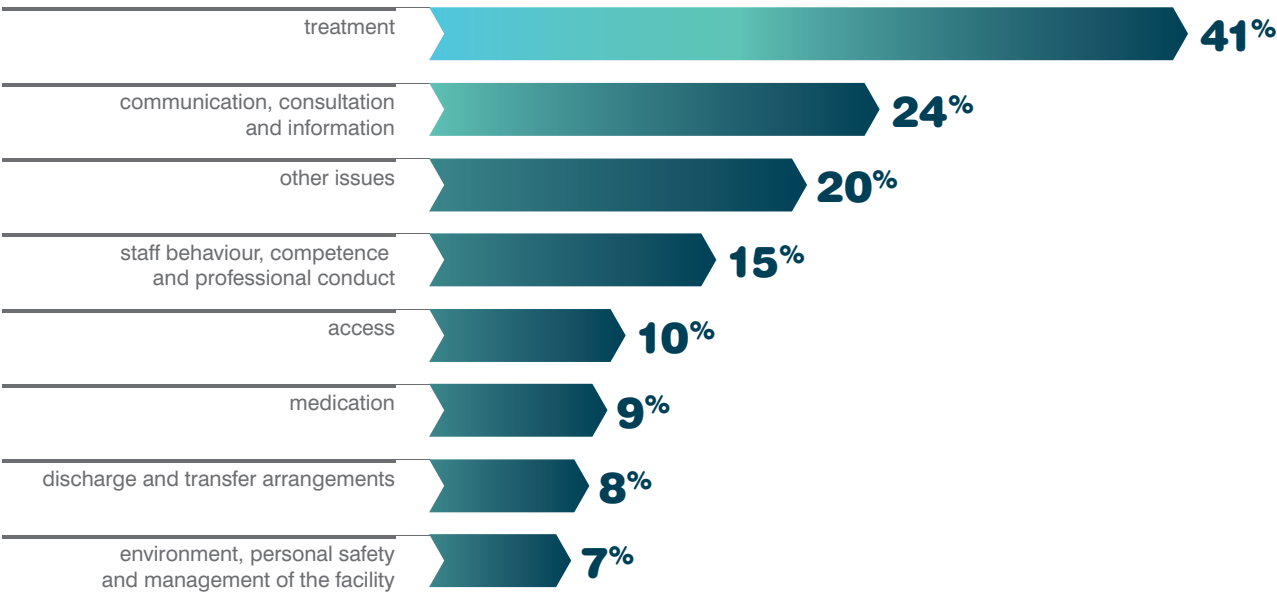


Key issues identified in all cases

Enquiries and complaints raised with our office are often complex, and most cases involve more than one issue. In this report, issues are described in terms of how often they occur in cases (frequency percentage). In light of many cases having more than one issue, the frequency percentages do not equal 100 per cent.

Treatment was, by far, the most common issue identified in new enquiries and complaints in 2015–16 (41 per cent). The next most common issue was concerns about communication, consultation and information (raised in 24 per cent of enquiries and complaints), followed by issues about staff behaviour, competence and professional conduct (15 per cent), access to services (10 per cent), discharge and transfer arrangements (8 per cent), and environment, personal safety and management of the facility (7 per cent), as shown in Figure 6. The common concerns raised about treatment, communication and staff behaviour suggest the need for services to work on ways of embedding recovery-oriented practice and the principles of supported decision making into treatment and care.

Figure 6
main issues raised in complaints



Treatment issues

Treatment issues commonly related to concerns about the decision to provide compulsory treatment, or the way this treatment was conducted (15 per cent of all enquiries and complaints). While decisions about compulsory treatment are reviewed and made by the Mental Health Tribunal, consumers often raise related issues with our office. These include concerns about how adequately a consumer's rights have been explained to them, the amount of information provided to them about their rights, and the extent to which their views and preferences in treatment have been taken into account, including those set out in advance statements.

Other common treatment issues included concerns relating to the adequacy or effectiveness of treatment (11 per cent), and specific concerns about medication (10 per cent). Common concerns included how adequately a service had consulted the consumer about medication options and side effects, and dissatisfaction with prescribed medication or changes in medication.

Other treatment issues included disagreements about a diagnosis or concerns related to a lack of explanation about a diagnosis (four per cent), delays in admission or treatment (two per cent), and issues with the development of or adherence to a treatment plan (two per cent).

Communication issues

Communication, consultation and information issues generally related to concerns about the adequacy of the information provided (raised in 11 per cent of all enquiries and complaints).

Other communication, consultation and information issues included insufficient consultation or the lack of inclusion of the consumer, family member or carer in the decision making process (nine per cent).

Communication concerns are often an underlying issue in complaints. They represent the need for services to dedicate time and attention to new types of conversation with consumers and carers, as required under the Act. Effective communication is key to achieving the objectives of the Act, which include enabling and supporting consumers to make or participate in decisions about their treatment and care, supporting their recovery, and recognising and respecting the role of families and carers.

Staff behaviour and conduct

A range of concerns were raised in enquiries and complaints about staff behaviour and conduct, including concerns about staff attitudes, and a perceived lack of empathy and respect in their interactions with consumers and carers (four per cent). These types of complaints point to the need for services to proactively address the potential stigma experienced by consumers, and ways in which they can improve the therapeutic engagement of staff with consumers, families and carers and ensure people feel heard and respected.

We also received a small number of complaints that involved alleged neglect, intimidation or assaults, some of which occurred in the context of the use of restrictive interventions (bodily restraint and seclusion). All complaints involving allegations of staff or practitioner misconduct were assessed for notification and referral to the Australian Health Practitioner Regulation Authority (AHPRA).

Our assessment and response to these types of complaints take into account the adequacy of investigations and responses made by the service, the status of police involvement, and in complaints that involve restrictive interventions, whether it is more appropriate for the matter to be dealt with by another body, including the Chief Psychiatrist.

Access to services

There was a range of access issues identified in enquiries and complaints that related to dissatisfaction with the assessment process, refusal by a provider or service to admit or treat a consumer, concerns about the adequacy or appropriateness of the service provided and delays and long waiting lists for services.

Other issues

While concerns about discharge planning were raised in a relatively small proportion of complaints (eight per cent), the impact of negative experiences of discharge planning were often significant for consumers, families and carers. Examples of issues relating to discharge planning include a lack of consultation with carers, discharge of consumers to unsatisfactory environments and risks to the wellbeing of both consumers and carers through early or inadequately planned discharge. These issues have been the subject of our recommendations to services to review policies and practices, and our discussions with the Chief Psychiatrist on the need for providing services with more detailed guidance.

A relatively small proportion of complaints related to the management of mental health facilities and people's sense of personal safety in these environments (seven per cent). Some of these issues were assessed as having a significant impact on consumers, such as adequate access to safe areas for women. These issues have also been the subject of recommendations to services to address people's right to be and feel safe in services.

Example complaint

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

Rosa, the mother of Sophia, contacted our office with concerns about her daughter's recent discharge from an acute inpatient unit. In speaking with a member of our Resolutions team, Rosa explained that she felt Sophia had been discharged without sufficient planning or support. Rosa said that she felt the service had not adequately communicated with her about her daughter leaving the unit and that despite Rosa having discussions with the service about her concerns, Sophia's discharge had proceeded. Shortly after being discharged, Sophia was readmitted as an inpatient for further treatment.

At the time Rosa had contacted us, both Rosa and the service manager agreed that Sophia was very unwell and would not be able to provide her consent to the complaint. Based on the information we received, we determined that there were special circumstances for us to accept the complaint without Sophia's consent and that doing so would not be detrimental to her wellbeing.

After speaking with our resolutions officer, the service manager offered to meet with Rosa to discuss her concerns and how to improve communication in future. Rosa said that while she appreciated the genuine efforts of service staff to resolve her complaint, she remained concerned about the need for improved discharge planning processes at the service.

We assessed the service's response, identified areas for improvement, and made a formal recommendation that the service review their discharge planning processes.

At the time of making our recommendation, we asked Rosa if Sophia would now be able to participate in the complaint. Rosa said she was comfortable with us discussing the complaint with Sophia, as she had recently been discharged from the hospital and was now living at home. Sophia agreed to the complaint proceeding and provided her views on how things could improve.

In response to our recommendation, the service agreed to review their processes. They also identified a number of projects that they had initiated to improve discharge planning, including reviewing their clinical practice guidelines with input from carers and consumers, and piloting a new discharge procedure with the support of peer workers.

As a result of this complaint and other complaints made to our office raising similar concerns, we identified systemic issues in approaches to discharge planning. We have since commenced discussions with the Chief Psychiatrist on the need for improved guidance on discharge planning for mental health services.



Overview of outcomes

In 2015–16, we dealt with 1,662 complaints, comprising 1,389 received during the year and 273 carried forward from 2014–15.

Of the 1,662 total complaints that we dealt with during the year, 1,410 were closed. Forty-six per cent of all complaints were closed within one week, a further 19 per cent were closed within one month, 11 per cent within two months, 6 per cent within three months, with the remaining complaints requiring more than three months to close, as shown in Figure 7. These statistics reflect the high number of oral complaints that we deal with, and our capacity to use informal processes to achieve timely resolution for these complaints.

Figure 7
time taken to close complaints

base: all complaints closed by the MHCC n = 1410

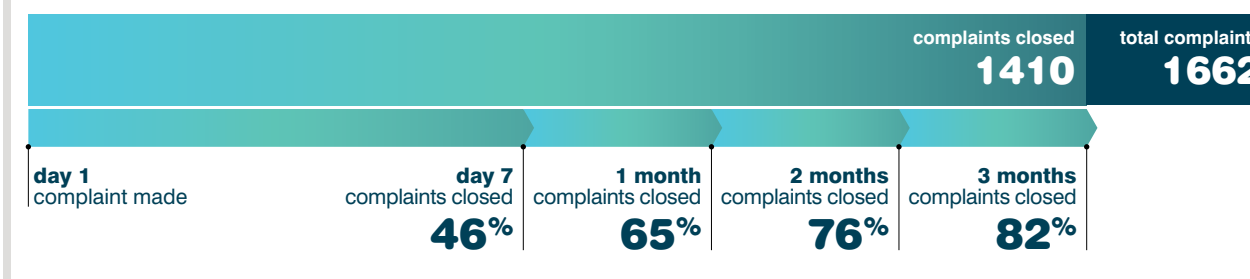
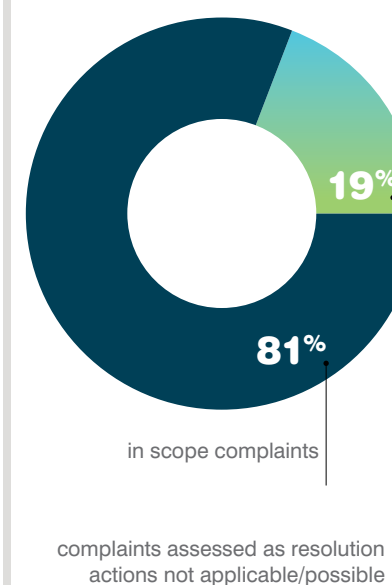


Figure 8
overview of outcomes for closed complaints



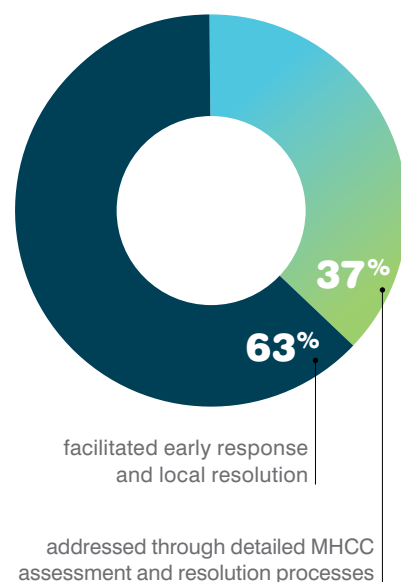
In 2015–16, 1,410 complaints were closed, with the majority closed as oral complaints (70 per cent). At 30 June 2016, 252 complaints were open in various stages of assessment, resolution or investigation. This is consistent with the average number of matters being dealt with at any time during 2015–16 (average 271 matters).

Of the 1,410 complaints that we closed in 2015–16, 272 were assessed as 'resolution actions not applicable/possible', as shown in Figure 8. We provide information and assistance to address the concerns raised in all matters that come to our office. For matters assessed as 'resolution actions not applicable/possible', we provide advice and information, and make follow up contacts and referrals, wherever possible.

The assessment of 'resolution actions not applicable/possible' is applied to complaints where resolution processes could not proceed because circumstances changed, the complaint was withdrawn, or there was no further contact from the person involved in the complaint.

This assessment is also applied to complaints that are outside the jurisdiction of the MHCC due to timing or type of service, or because it was more appropriate for the matter to be dealt with by another body such as the Mental Health Tribunal (e.g. where the key issue was about being on a compulsory treatment order). In all, 206 complaints were closed for these reasons (76 per cent of complaints assessed as 'resolution actions not applicable/possible', equating to 19 per cent of all closed complaints).

Figure 9
resolution outcomes for
in scope complaints



Resolution outcomes for 'in-scope' complaints

To provide an accurate picture of the work undertaken by our office to achieve resolution outcomes in closed complaints, we exclude all matters assessed as 'resolution actions not applicable/possible' and categorise the remaining cases as 'in-scope' complaints.

In 2015–16, 1,138 closed complaints were assessed as being in-scope, as shown in Figure 8.

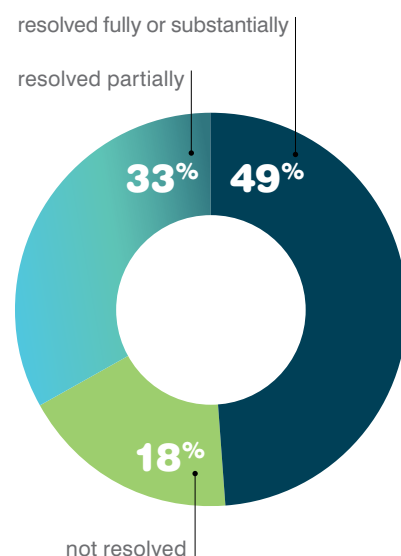
We achieved positive outcomes in 1,062 of the 1,138 closed in-scope complaints (93 per cent) either through our office facilitating an early response and local resolution by the service, or by the concerns being fully or partially resolved through detailed MHCC assessment and resolution processes, as shown in Figure 9.

We facilitated an early response and local resolution by the service in 717 (63 per cent) complaints without the need for the complaint to be confirmed in writing and formally accepted by our office. For the majority of these complaints, we engaged in a number of discussions with all parties to clarify the issues and facilitate resolution. In most instances, we provided advice to the service on ways to resolve the issues, and confirmed agreed actions, answers and explanations from the service in response to the person's concerns.

In the remaining 421 (37 per cent) of 1,138 closed complaints that were assessed as being in-scope, we conducted comprehensive assessments of issues, and undertook a range of resolution activities, including reviewing written responses and actions taken by services, and facilitating teleconferences and meetings. The outcomes of these 421 complaints were as follows, and are shown in Figure 10:

- **Resolved fully or substantially** 206 of 421 (49 per cent): In these complaints, issues were either fully or substantially resolved, or an agreement was reached on the proposed actions to address the issues raised. Overall these complaints achieve a positive outcome in terms of the person's concerns.
- **Resolved partially** 139 of 421 (33 per cent): In these complaints, resolution was achieved for one or more of multiple issues raised, or partial resolution was achieved for a single issue. Partially resolved complaints included those complaints where the service committed to improvement actions, but where the concerns were not resolved to the satisfaction of the individual.
- **Not resolved** 76 of 421 (18 per cent): In these complaints, there can be barriers to achieving a positive outcome, such as not being able to reach agreement on the outcomes sought by the person to address their concerns. We recognise that it is not always possible to resolve complaints made to our office. Where appropriate, we provide advice and recommendations to the service or to the individual about other possible courses of action, including referral options to other bodies.

Figure 10
resolution outcomes for in scope
complaints closed through detailed
MHCC assessment and resolution
processes



The 'Four As' 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 do not want a recurrence of the issue for themselves or for others, and because they want services to take actions to achieve this.

Apology

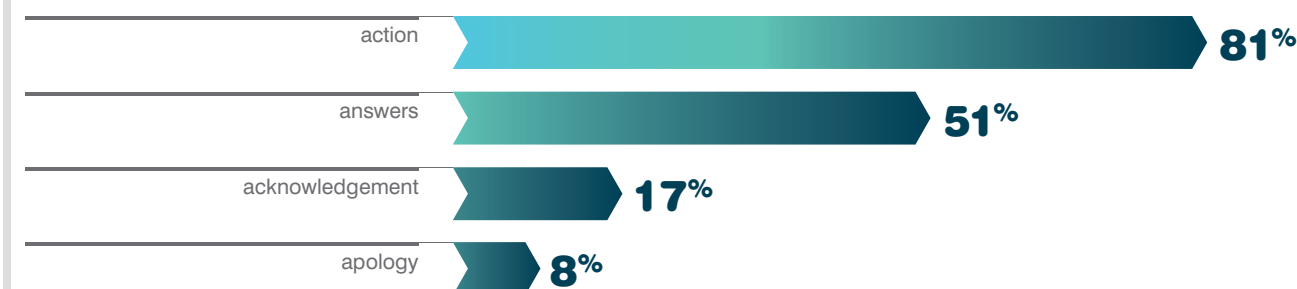
A meaningful apology normally involves acknowledgement, answers and actions by a service and when appropriate, can assist in a person's recovery and help to restore confidence in the service.

How complaints were addressed and resolved: the 'Four As'

When the outcomes of complaints were categorised into the 'Four As' of complaint resolution, 81 per cent recorded an action outcome, 51 per cent resulted in explanations or answers in relation to the issue raised, 17 per cent recorded acknowledgements by the service and 8 per cent resulted in an apology from the service, as shown in Figure 11.

While we have seen some positive outcomes achieved through the provision of genuine acknowledgements and apologies by services for adverse events and interactions experienced by consumers and carers, we continue to work with services on strengthening these important ways of resolving complaints and supporting people's recovery.

Figure 11
outcomes of complaints – 'Four As'



The provision of meaningful answers and explanations to issues raised in complaints was the single most common way in which complaints were resolved, whereas actions taken in response to complaints were wide ranging.

The most common actions to address individual concerns were:

- addressing communication issues and processes between consumers, families, carers and services
- improving the way in which services or supports are provided to the consumer
- reviewing or developing the consumer's treatment/recovery plan
- arranging access to a second psychiatric opinion
- changing the consumer's treating practitioner or case manager
- providing or offering appropriate services.

The most common types of service improvement actions were:

- reviewing practices to prevent or minimise a reoccurrence of the issue
- changing or reviewing relevant policies or procedures
- improving staff training and supervision.

We have been pleased with the ways in which services have identified opportunities for service improvements and have confirmed a range of service improvement actions as outcomes of individual complaints. In 2015–16, 73 improvements were initiated by mental health services as outcomes of complaints made to the MHCC.

We also provided 53 formal recommendations to services to review policies or practices, with the aim of preventing or minimising the reoccurrence of issues identified in complaints and to promote service improvements. These included detailed recommendations made from two formal investigations that we completed in 2015–16. An overview of the areas addressed in our recommendations made to services under the Act is included in the section about promoting service and system improvement (see page 38).

Investigations

When determining whether or not to conduct a formal investigation, we consider a range of factors, including the seriousness of the concerns or allegations, and whether the complaint raises practice or systemic issues which require detailed review. Other considerations include whether there are significant facts in dispute or in need of being determined, and whether these issues are more appropriately dealt with by another body, such as the Coroner, the Chief Psychiatrist or the Mental Health Tribunal.

In 2015–16, we completed two formal investigations under Part 10, Division 4 of the Act. The two investigations addressed multiple and serious issues including:

- responses to an alleged assault in an inpatient unit
- alleged detriment to a consumer as a consequence of making a complaint
- a serious adverse event in an inpatient unit
- related issues associated with the adequacy of community care, risk assessments, family and carer engagement, discharge planning and responses to disability support needs.

The purpose of these investigations was to investigate the adequacy and appropriateness of services provided to the consumer, the service's response to the issues and to make recommendations on the areas identified in the investigation for service improvement.

For both investigations, the Commissioner appointed a panel with relevant specialist expertise to conduct interviews and review documents, including clinical records and policies and procedures and to provide expert opinion and findings. The staff at each service cooperated fully throughout the investigation process. We prepared reports on both investigations for the services, detailing our findings and recommendations on resolving the issues presented, and on specific areas for practice and service improvements. Further information about our recommendations is provided in the section about promoting service and system improvement (see page 38).

Our priorities

We continue to further develop our practices to improve the timeliness and effectiveness of our work in resolving complaints. We look forward to achieving a higher level of functionality in our case management system to support these processes and enable improved data capture and analysis. Increasing people's awareness of the range of service improvement actions taken by services as a consequence of complaints will play an important role in building the confidence of consumers, families and carers to raise concerns directly with their service.

Local complaints reporting





Our role

Under the *Mental Health Act 2014* (the Act), all public mental health services, including designated mental health services (DMHS) and Mental Health Community Support Services (MHCSS), are required to provide a twice-yearly complaints report to the Mental Health Complaints Commissioner (MHCC).

These reports must specify the number of complaints received by the service and the outcomes of these complaints.

We collate and analyse this data, identifying key themes and emerging issues across the sector in order to inform projects and recommendations and increase sector knowledge of systemic issues and opportunities for improvement. The data also provides valuable insights into the concerns and experiences of consumers, families and carers, and the current status of complaint processes and reporting systems across the sector.

Our approach

We consult and collaborate with mental health services and the Department of Health and Human Services (DHHS) on data collection and reporting mechanisms in place across the sector. Our goal has been to identify ways in which existing systems can be enhanced to meet complaints reporting requirements under the Act, and to produce meaningful complaint data to inform service and systemic improvements.

The absence of a standardised platform to collect and report data across services has presented challenges in achieving our goal.

Our approach has been informed by a detailed review and analysis of the first round of complaints reporting by mental health services for the period 1 July–31 December 2014. As noted in our 2014–15 annual report we identified significant issues in relation to data collection during this period. Issues included significant gaps and inconsistencies in the data provided and issues captured. We worked to address these issues in round two of the implementation of a local complaints reporting system.

Implementation of round two of local complaints reporting

In order to address the issues identified in round one, our local complaints reporting work in 2015–16 focused on two key areas:

Contributions to the VHIMS2 improvement project

Many of the challenges identified in round one of local complaints reporting were a result of issues in the reporting fields and functionality of the Victorian Health Incident Management System (VHIMS), the platform used by all DMHS for recording incidents and complaints.

In 2015–16, we were a key contributor to DHHS's VHIMS2 project, the aims of which include improving the reporting functionality of the system and the data delivered. We contributed to broad based sector consultations alongside 42 services, and were heavily involved in the preliminary stages of system redesign. We also met with the DHHS project team and software vendors to provide expert advice on user interface and functionality improvements, as well as data set revisions. We will continue to provide input and recommendations to the project team to ensure the challenges faced by services in local complaints reporting are considered in the delivery of the new and improved system.

Collection and analysis of complaints reports for 1 January – 31 December 2015

At the same time as contributing to future improvements to the VHIMS platform, we engaged a research company to develop a common complaints reporting tool that included detailed guidance instructions for services on the types of data fields to be extracted from VHIMS or other complaint data systems used by services.

Taking into account the time and resources required for data collation, audit and analysis, we consolidated the bi-annual reports required from services for the calendar year 1 January–31 December 2015 into one reporting period. This took into consideration the lessons learned from the first round of reporting and recommendations made to improve the consistency of the data. It also enabled us to conduct a comparison of the data to complaints made to the MHCC for the same period.

While there were some improvements in the data reported by services in the second round of complaints reporting, considerable work was still required to produce a consistent, combined data set that would enable meaningful comparison and analysis of the data. This data analysis was subject to independent data validation and quality assurance processes by the same research company used for the first round of complaints reporting.

Results and next steps

The approach adopted by services for the second round of complaints reporting has produced a more detailed and comparative analysis of the numbers, themes and outcomes of the complaints reported by mental health services. This analysis has identified some notable similarities and differences between complaints reported by services and complaints made directly to the MHCC for the same period, which are outlined below. The analysis has also identified issues to be addressed through planned improvements to current complaints reporting systems.

In this second round of reporting, we were also able to make comparisons between the number of complaints reported by services and the number of consumers registered with services for the same period (as reported to DHHS) and to calculate an average rate of complaints per 1,000 consumers per type of service.

The analysis from the second round of reports provides a valuable starting point for discussions with services about potential areas for improvement in approaches to recognising, recording and reporting complaints, as well as areas for service improvement across the sector. To facilitate this, we will be producing individual reports for each service to enable them to compare their complaints to the complaints made about their service directly to the MHCC, and to aggregated data from similar service types.

Caution should be used when drawing conclusions from relative numbers of complaints reported by services. Higher numbers of complaints reported by services may represent effective complaints reporting processes and/or a positive complaints culture. It may also demonstrate high numbers of issues experienced by people who use the service. 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.

The purpose of the next round of analysis of complaints reporting data and discussion with services is not to benchmark services, but to understand the trends and differences in data, and to identify opportunities for further consideration and improvement.

A NOTE ABOUT THE DATA IN THIS SECTION

Caution should be used when interpreting the data from complaints reported by services, as it may not be representative of all complaints dealt with by services over the reporting period. This is due to the issues identified in existing data collection and reporting. While quality assurance and data integrity checks were undertaken, it is possible that some out-of-scope matters were included in complaints reports by services, and different approaches to categorisation of issues and outcomes may have affected the data.

Please note that the numbers and percentages of complaints made to the MHCC used in this analysis are for the period 1 January–31 December 2015, and therefore differ from those reported for the 2015–16 reporting period in this report.

The following overview provides a comparative analysis of data from complaints made to services and to the MHCC for the period 1 January–31 December 2015. It is confined to comparisons of numbers, service types, issues, sources of complaints and outcomes. The MHCC complaints data for the period 1 January–31 December 2015 has been collated and included below to provide direct comparisons to the data from complaints reported by services.

Overview of complaints reported by services for period 1 January–31 December 2015

Thirty-three of the 36 organisations (92 per cent) providing public mental health services in Victoria reported a total of 1,640 complaints over the period 1 January–31 December 2015.

This represents a pro-rata increase of 11 per cent in reported complaints, in comparison to the total of 736 complaints reported by services for the six-month period 1 July–31 December 2014. Despite this increase, the total number of 1,640 complaints is still likely to represent an under-reporting of complaints made directly to services.

Complaints reports were received from 18 DMHS and 15 MHCSS. Thirty-two of these organisations recorded at least one complaint, while one provided a 'NIL return', indicating no complaints were recorded over the reporting period.

Comparison of complaints reported by services and complaints made to the MHCC

A total of 1,640 complaints were raised directly with mental health services during 2015 and reported to the MHCC ('reported complaints'), compared to 1,199 complaints made directly to the MHCC ('MHCC complaints'). Accounting for the 338 enquiries that were also raised with the MHCC over this period,¹ a total of 1,537 enquiries and complaints were raised with the MHCC in 2015, as shown in Figure 12.

Our goal is to see a much higher proportion of complaints raised directly with services as a result of people being able and confident to do so, and as a result of complaints being recognised, resolved and reported by services.

Figure 12
number of matters raised with service providers and the MHCC
(1 January – 31 December 2015)



1. The number of enquiries raised directly with providers was not recorded as part of the local complaints reporting process



Number of complaints by type of mental health service provider

The vast majority of reported complaints were in relation to services provided by DMHS, with a much smaller number of complaints made about MHCSS. A total of 1,467 reported complaints (89 per cent) were from DMHS, with 173 (11 per cent) from MHCSS, as shown in Figure 13.

Of the complaints raised directly with the MHCC, the majority were about DMHS (95 per cent), with far fewer about MHCSS (5 per cent).

Comparing the number of complaints made to the number of consumers receiving services provides an indication of the extent to which people are inclined to raise complaints with different services. It also facilitates comparisons between services and across time.

There was an average of 18 reported complaints made to services per 1,000 consumers for 2015, compared to an average of 12 complaints per 1,000 consumers raised directly with the MHCC.

DMHS had a far higher complaint rate than MHCSS in 2015, as shown in Figure 14. This could be indicative of a number of factors, including differences in the context and nature of the services provided (e.g. compulsory treatment) and differences in approaches to complaints.

The number of reported complaints per 1,000 consumers was over twice as high for DMHS (20) as for MHCSS (9).

The number of complaints made directly to the MHCC per 1,000 consumers was almost six times as high for DMHS (14) as for MHCSS (2).

A comparison of complaint rates between services showed considerable variation, particularly among DMHS. While nine DMHS (50 per cent) reported more than 20 complaints per 1,000 consumers, five (28 per cent) reported fewer than 10 complaints per 1,000 consumers.

In several cases, services that reported a relatively low number of complaints per 1,000 consumers were among those with the highest rate of complaints reported about them directly to the MHCC.

Figure 13
number of complaints by type of service provider
(1 January – 31 December 2015)



* An additional 161 complaints made directly to the MHCC were not related to DMHS or MHCSS. These complaints are not shown in this figure to maintain direct comparability with reported complaints.

Figure 14
complaints per 1,000 consumers by type of service provider
(1 January – 31 December 2015)



Issues raised in complaints

The three issues that were most commonly raised in reported complaints were staff behaviour or conduct issues (29 per cent), treatment issues (28 per cent) and issues about the environment and management of the mental health facility (25 per cent).

In contrast, half of all complaints made to the MHCC were about treatment issues, with communication issues (32 per cent) the next most common area of concern. These differences in the proportions and types of complaints are similar to those identified in the analysis of the first round of complaints reporting. One of the questions raised by the higher proportion of treatment related complaints being made to the MHCC in comparison to those reported by services, is whether concerns raised directly by consumers or carers with treating teams are being recognised, responded to and recorded as complaints.

There was also variation within broad issues categories between reported complaints and MHCC complaints, as shown in Figure 15. For example, within the category of staff behaviour and conduct, the complaints reported by services were more than twice as likely to be described as ‘poor staff behaviour or attitude’ (20 per cent) than were complaints made to the MHCC (9 per cent).

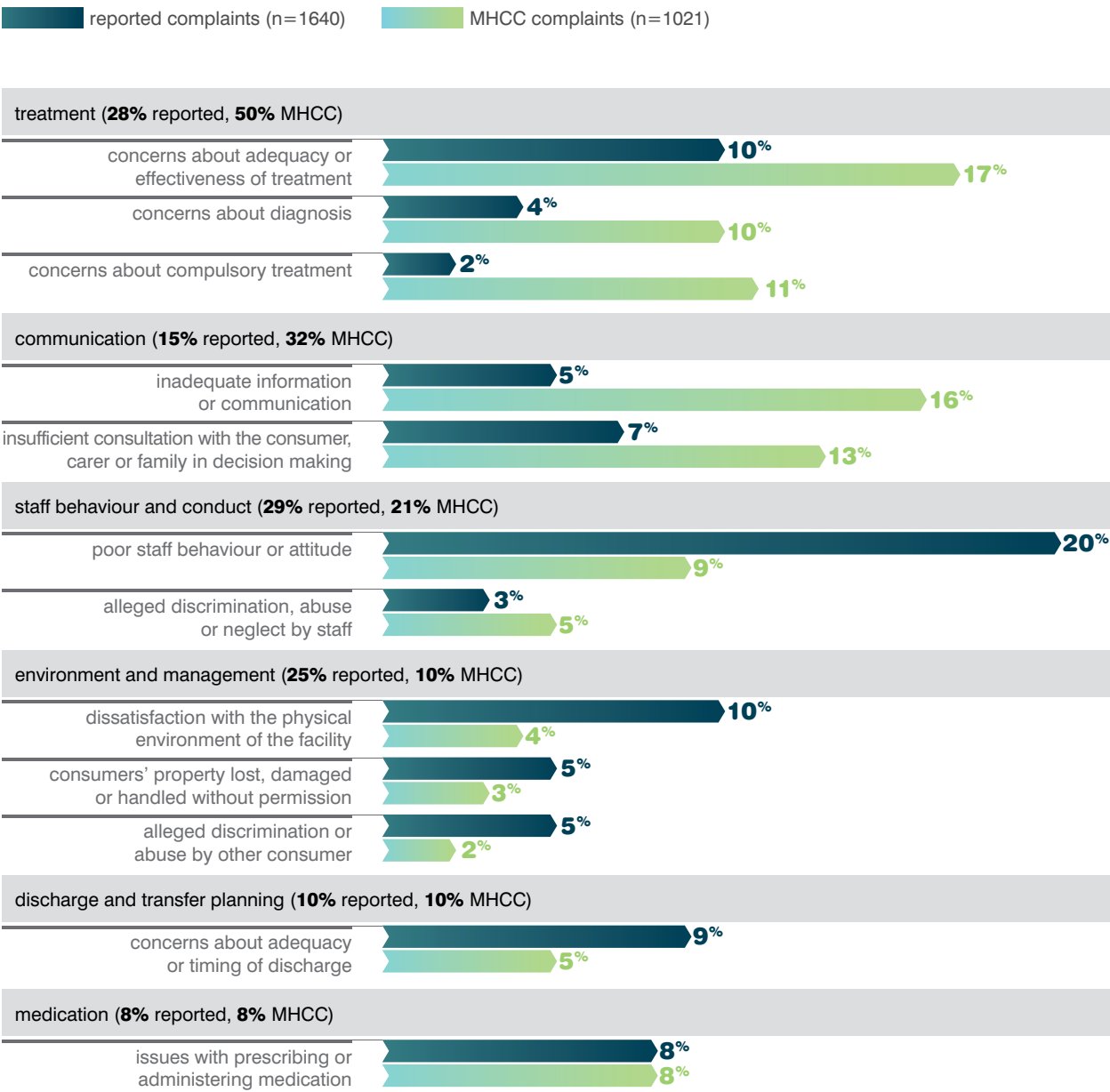
These differences in themes and proportions of issues raise a number of questions that we will seek to explore with services in our discussions about these results, and in our consultations with consumers, families and carers in relation to their experiences in raising complaints. The common themes of staff behaviour and conduct, and treatment issues in reported complaints suggest services should consider ways in which the principles of the Act, particularly recovery-oriented practice and supported decision making, can be embedded into all aspects of treatment and care.

We have also identified the need to seek more information on the types of actions taken by services in response to complaints about staff behaviour and attitude, and for this data to inform broader workforce development being undertaken across the sector.

More information will be sought on the types of complaints being made to services about issues of environment and management of facilities in order for these complaints to inform approaches to improving the amenity and safety of services across the sector.



Figure 15
issues raised in reported and MHCC complaints*
(1 January – 31 December 2015)



* This figure displays broad higher level and sub level categories raised in at least four per cent of complaints.



Service program types

Complaints made directly to the MHCC were more commonly about DMHS adult services (82 per cent) than were complaints reported by services (67 per cent). Ten per cent of reported complaints were about Child and Youth Mental Health Services (CYMHS) or Child and Adolescent Mental Health Services (CAMHS), with a similar proportion about MHCSS. This is in comparison to complaints about all other service types made directly to the MHCC, which each accounted for less than 5 per cent of total complaints, as shown in Figure 16.

A slightly higher proportion of complaints made directly to the MHCC were about inpatient services (65 per cent) than those reported by services (58 per cent). In both cases almost all of the remaining complaints were about community services, as shown in Figure 17.

People who made complaints

Complaints made by consumers accounted for 61 per cent of reported complaints compared to 69 per cent of MHCC complaints. Similarly, the proportion of complaints made by families or carers was higher among complaints made to the MHCC (26 per cent), than among those reported by services (24 per cent).

Nine per cent of all reported complaints were complaints that were first made to the MHCC. We continue to work with services on ways in which consumers, families and carers can be encouraged and feel confident to raise concerns directly with services.

Complaint outcomes

Complaint outcomes were reported in 430 complaints to services (26 per cent), with outcomes much more commonly included in complaints reported by MHCSS (83 per cent) than in those reported by DMHS (19 per cent).

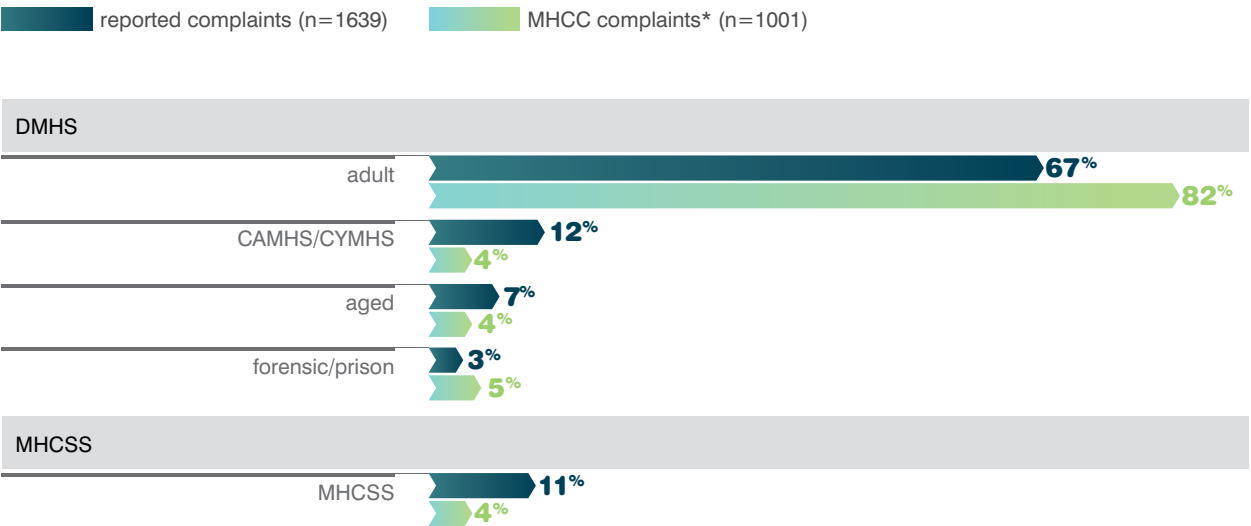
Due to data limitations in relation to complaint outcomes reported by services, it is not possible to provide a reliable and direct comparison to outcomes of complaints made to the MHCC.

The limited amount of data reported on complaint outcomes and service improvement actions is a key priority to address in the next round of complaints reporting. Information on these outcomes is vital to building the confidence of people to raise concerns and to inform broader service and system improvements.

Our priorities

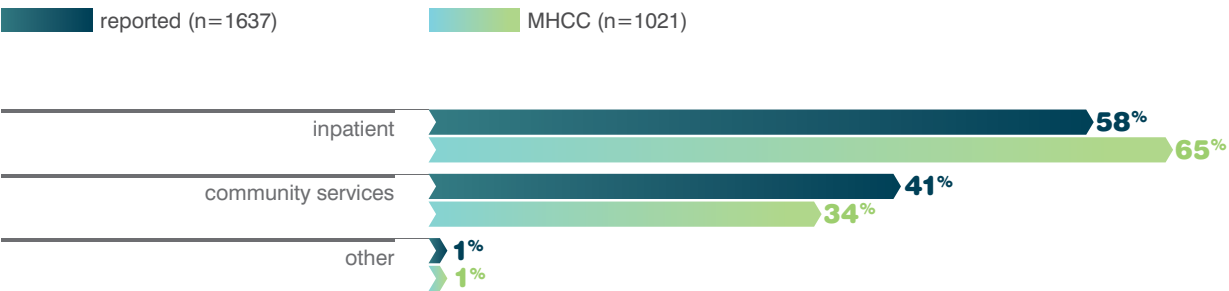
We will continue to work with mental health services and with DHHS on the development of improved complaints reporting systems and processes. We anticipate that these improvements will support services in meeting their complaints reporting requirements, and optimise the opportunities for contributing to service and systemic improvements, including in specific areas such as workforce development and approaches to complaints. We will continue to contribute to the VHIMS2 improvement project, review the information identified in individual service complaints data and complaints made to the MHCC, and implement improvements to current reporting processes.

Figure 16
service types subject to complaint
(1 January – 31 December 2015)



* An additional 20 complaints made directly to MHCC were about an 'other' service type. These complaints are not shown in this figure to maintain direct comparability with reported complaints.

Figure 17
service setting types subject to complaint
(1 January – 31 December 2015)





Promoting service and system improvement



Our role

Under section 228 of the *Mental Health Act 2014* (the Act), the Mental Health Complaints Commissioner (MHCC) 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 and to make recommendations for improving mental health services.

Our approach

We use information that we gain from complaints to provide insights into people's experiences of services, and to inform service and broader system improvements. We have been pleased to see an increasing number of service and practice improvements initiated by services as outcomes of complaints made to the MHCC.

We have also made greater use of our powers to make formal recommendations to services, and to the Secretary of the Department of Health and Human Services (DHHS), to address policy and practice issues identified in complaints. These recommendations will lead to service improvements in a wide range of areas, as outlined below.

We are committed to sharing the knowledge and experience that we have gained in our first two years of operation. In 2015–16 we participated in a wide range of forums and consultations relating to Victorian mental health services and the broader service system, enabling us to build our knowledge and connections, inform our work, and create opportunities to collaborate to promote service and system improvements.

Service improvement initiatives through complaints to the MHCC

In 2015–16, a total of 126 improvements to mental health services were identified as a result of complaints made to the MHCC, including the results of two investigations. Of these, 73 improvements were initiated by services through working with us to resolve complaints and 53 occurred in response to recommendations made by our office to address policy, quality and safety issues, as identified in our assessment as well as investigation of complaints.

Services initiated many improvements as a result of detailed and thorough responses, which aimed to prevent a recurrence of the issues raised in the complaint. In some complaints, the service undertook a comprehensive review of the concerns raised and developed an action plan to address policy and practice issues.

Services identified the need to provide staff training in response to 16 individual issues, including in areas such as compliance with the Act, requirements relating to the making of compulsory orders, complaints management, communication with consumers and families, advance statements, practices in relation to gender safety and the right to communicate.

Services initiated the review or development of 27 policies and procedures in relation to a wide range of areas. These included policies and procedures relating to discharge planning and the involvement of families and carers, processes for communication with consumers, families and carers about treatment issues and adverse events, the development of information packs for consumers and families on various issues and processes for encouraging feedback. Other specific procedural areas addressed by services included processes for ensuring appropriate information is noted on clinical records, notifying relevant parties of Mental Health Tribunal hearing dates, record keeping on consumer's legal status, and procedures for securing consumers' personal property when in inpatient units and ensuring the cleanliness of facilities. Policy reviews initiated by services as outcomes of complaints also addressed areas such as a consumer's right to communicate under the Act, risk assessments and care planning, leave approvals and management strategies and responses to incidents.

Services also initiated 22 practice changes to address a range of issues identified in complaints. These changes in practices included changes to approaches to the provision of information about medication and treatment, engaging with consumers about their preferred methods of communication, practices for seeking consent from consumers about the sharing of health information and information sharing with families, and communication and decision making processes for discharge planning. There were also a number of specific practice changes made in relation to risk assessments and treatment in high dependency units.

In addition, services initiated eight improvements to address specific issues identified in areas such as communication, performance management and supervision of staff, and roles and responsibilities of senior on-call staff in relation to incidents.

Service improvement recommendations made by the MHCC

Recommendations to services arising from complaint assessment and resolution

Sixteen formal recommendations were made to services as a result of our complaint assessment and resolution processes. These recommendations related to reviews of policies and procedures across areas, including the provision of debriefing and supports following the use of bodily restraint and/or seclusion, approaches to investigation of complaints, communication with carers, supporting consumers appropriately when implementing smoke-free environments, processes for ensuring access to Mental Health Tribunal reports within the statutory timeframes, the right to communicate (particularly in relation to access to electronic devices), and the implementation of practices to support the least restrictive treatment and promote safety in inpatient units.

We also made recommendations in relation to staff training, including training in supporting consumers to report relevant matters to police, and in consumer rights and service responsibilities under the Act.

Recommendations to services arising from complaint investigations

We made a total of 37 recommendations for service and practice improvements in the two formal investigations completed by our office in 2015–16. Both services cooperated fully with our investigations and have taken the opportunity to review their practices, processes and policies. All of the recommendations made in the first investigation were accepted and implemented by the service. As at 30 June 2016, the recommendations from the second investigation were under consideration, with the service participating in further discussion with our office about the areas identified for improvement.

While these recommendations were unique to the circumstances of each complaint, there were a number of common themes and areas identified, as discussed below.

Complaints management: Our recommendations included ensuring the roles of staff in responding to complaints are made clear, and that the treating clinicians refer any complaint made about them to a senior staff member. We also recommended that steps are taken to ensure that management and other staff understand their obligations under the Act to ensure no detrimental action is taken or implied as a consequence of a person making a complaint to our office. Other recommendations included ensuring information about how to make a complaint, including to our office, is clear, accessible, and provided to consumers, families and carers.



Investigation of alleged assaults: Our recommendations addressed areas such as appropriate engagement and follow up with Victoria Police, protocols on the appropriate level of independence and expertise required to conduct internal investigations, and the provision of support to the consumer in providing their account of events. Other areas of recommendation included the need for clear terms of reference for external investigators reviewing serious incidents. Our findings identified the need for services to be provided with more detailed guidance and standards for investigations of alleged assaults, which informed our recommendations to the Secretary of the Department of Health and Human Services (DHHS), as discussed below.

Responding to the needs of people with disability: Our recommendations aimed to improve care provided in specific circumstances (e.g. working more closely with the range of agencies providing support to the person concerned), and to respond to the holistic needs of people with disability. Other recommendations supported the broadening of access to specialised training for staff and engaging DHHS Disability Services to ensure joint consideration of disability support and mental health needs. Our recommendations also included ensuring disability support needs are taken into account in the provision of treatment and care, and that a policy be developed to provide the necessary framework and guiding principles.

Working with nominated persons, families and carers:

Our recommendations included ensuring the timely notification of nominated persons, families and carers about serious incidents, ensuring staff capability to support effective responses to complex family situations and trauma, and developing practice guidelines to ensure the needs of dependent children are considered as part of regular clinical reviews. Other areas of recommendation included the need to seek and review the consumer's views and preferences for family involvement at regular intervals, and for families and carers to be encouraged to discuss any concerns they have about the consumer's wellbeing with the service at any time.

Case management practice for community based care:

Our recommendations included that services should provide appropriate psycho-education to consumers and families, ensure that previously documented clinical information (e.g. early warning signs) is considered in subsequent clinical reviews and that shared care arrangements clearly specify that only one service is responsible for prescribing psychotropic medication.

Quality and safety issues in inpatient care: Our recommendations included improving the physical structure of the inpatient unit, observation of consumers in acute inpatient units, access to additional staffing support at times of increased levels of acuity, and responses to allegations of assault and other incidents.

Discharge planning: Our recommendations addressed areas relating to discharge planning, including the need for the service to review their relevant guidelines and reinforce the requirement for collaboration with consumers, families and carers. Other recommendations included ensuring these guidelines address the needs of dependent children and aged people who may normally be dependent on the consumer, in keeping with the principles of the Act, and providing staff with training on the revised guidelines. For situations where multiple agencies are involved in a person's care or where discharge is complex, our recommendations included ensuring meetings are formalised and follow a consistent structure, and that written discharge plans are provided to consumers, families and carers.



Recommendations made to the Secretary of the Department of Health and Human Services

In 2015–16 we made four recommendations to the Secretary of DHHS as a result of systemic issues identified through conducting investigations (see above) and resolving other complaints. Our recommendations related to the following areas:

Categorisation and notification of incidents of alleged ‘staff to client’ assaults in designated mental health services: We recommended that incident reporting guidelines for all mental health services clearly specify that alleged staff to client assaults are recorded as Category 1 incidents to ensure these incidents are appropriately escalated and addressed by senior management.

Standards and requirements for investigations into alleged assaults and adverse events: We recommended that specific guidance be provided to mental health services on the requirements for the investigation of alleged assaults and adverse events to ensure adherence to accepted standards of investigation, and that consumers are supported to provide their account of events.

Reporting and protocols with police regarding alleged assaults within services: We recommended providing greater guidance to mental health services in relation to involving police in matters involving alleged assaults, and providing greater clarity on reporting requirements and expectations of police involvement in these matters. We recommended reviewing the specific issues identified within designated mental health services as part of work that is currently being progressed by DHHS.

Policy, practice guidance and training for mental health staff in relation to the needs of consumers with a dual disability: In a number of complaints, we identified a lack of specific policies or training for mental health staff in responding to the needs of people with a dual disability (mental illness and intellectual disability). As such, we recommended that this issue be considered by DHHS.

We are pleased that the Secretary has noted these important issues and referred these recommendations to DHHS for consideration.

We are also pleased to be advised and consulted about the following important initiatives that have been taken by DHHS in response to our 2014–15 recommendations:

Inpatient access to mobile phones and other communication devices: DHHS have advised that this issue has been brought to the attention of mental health services and there have been some changes in practices to ensure compliance with the requirements and principles of the Act. DHHS is developing a policy and practice guide on access to mobile phones and other communication devices for consumers during inpatient admissions.

Fees charged for Secure Extended Care Units (SECUs): In response to our recommendation, DHHS is reviewing guidelines used by services to charge fees for SECUs and developing a policy that is consistent with the Act and contemporary practice within healthcare settings.

Use of restrictive interventions in emergency departments: DHHS has established a Mental Health/Emergency Department Steering Committee, and has planned a review of the *2007 Mental Health Care: Framework for emergency department services*. We have been advised that the Chief Psychiatrist and Chief Mental Health Nurse are undertaking a program of work to ensure appropriate care is being provided to consumers who present to emergency departments, and that emergency department staff comply with the requirements of the Act.

Example complaint

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

Mary made a complaint to our office about her experiences of being placed on a temporary treatment order after being admitted to a hospital general ward. When speaking with a member of our resolutions team, she described feeling in a state of shock and not understanding why she was being treated as a compulsory patient.

Mary told us that she had not been able to telephone her lawyer privately and had not been provided with any information about her rights. She spoke of feeling intimidated and threatened by one staff member during her time at the service, and that these issues had been raised with one of the treating clinicians in an appointment after she had been discharged. Mary said she wanted the service to understand how traumatic her experience had been, and take action so that other people did not have similar experiences.

We assessed that Mary’s complaint raised a number of issues under the *Mental Health Act 2014* (the Act), including the right to communicate privately, the provision of a statement of rights, and the principle that people receiving mental health services should have their rights, dignity and autonomy respected and promoted. We asked the service to provide a formal response to these issues, and to outline steps that had been taken to address the specific allegations about the staff member concerned.

We facilitated a conference to enable Mary to convey her experience and the impact it had on her to the service, and to allow the service to respond directly to her concerns. At this meeting, the service representatives acknowledged Mary’s experiences, apologised for what had happened, and confirmed that a number of actions had been taken to ensure all staff were aware of their obligations under the Act. They also advised that the actions of individual staff members had been investigated and that relevant staff had been counselled.

Mary said that the experience of being heard and receiving a direct apology by senior management was most important to her and that she felt the service had taken her concerns seriously. Mary said she appreciated being asked by the service to share her experiences as part of staff training aimed at preventing other compulsory patients from having similar experiences.

The issue concerning the alleged conduct of the staff member was investigated by the service but remained unresolved due to disputed accounts and a lack of witnesses and other evidence. While Mary did not want to pursue her complaint any further, we identified the need for further review of the adequacy of the investigations and actions taken by the service. We also sought confirmation that the Australian Health Practitioner Regulation Agency was considering the notification made about the alleged conduct of the staff member concerned.

We confirmed the actions taken by the service to ensure compliance with the requirements of the Act, specifically the provision of information about the legal status and rights of compulsory patients and the provisions in relation to the right to communicate. We also made formal recommendations to the service to address gaps in their local complaints and investigation processes, and to promote improvements in these areas.



Participation in Victorian sector consultations and forums

We continued to contribute our experience and knowledge by taking part in a wide range of consultations and forums, enabling us to identify emerging themes and opportunities for service improvements.

These included regular meetings with:

- DHHS senior executives and the Chief Psychiatrist to discuss emerging issues and sector developments
- Mental Health Senior Leaders groups for clinical services and for Mental Health Community Support Services to discuss themes identified in complaints
- the Consumer Partnership Dialogue Forum and the Carer Partnership Dialogue Forum (as an associate member)
- peak bodies such as:
 - Victorian Mental Illness Awareness Council, the peak body for people with lived experience of mental health or emotional issues
 - Tandem, the peak body for families and carers of people in Victoria experiencing mental ill-health
 - VICSERV, the peak body for community managed mental health services in Victoria
- other statutory bodies such as the Mental Health Tribunal, Health Services Commissioner, Office of the Public Advocate, Australian Health Practitioner Regulatory Agency (AHPRA), Victorian Ombudsman, Disability Services Commissioner and Victorian Equal Opportunity and Human Rights Commission to identify emerging issues and ensure effective referrals.

Contributions to consultations, projects and advisory/reference groups

In 2015–16, we responded to 16 requests to provide input into a number of key projects and consultations, including *Victoria's 10-year mental health plan*, the Victorian Health Reform Summit: Health 2040, the proposed new Critical Client Incident Management System for agencies funded by DHHS, and the review of the Victorian Hospital Incident Management System (VHIMS2 Project).

We also participated in a number of advisory and reference groups to support related areas of work. These groups included the Independent Mental Health Advocacy Reference Group, Second Psychiatric Opinion Advisory Group (DHHS), Participation Advisory Committee (DHHS) and the Open Minds' Board, which works to decrease the stigma of mental illness for consumers and carers in the Victorian Public Service.

In addition we participated in consultations on issues relating to access, quality and safeguards for the National Disability Insurance Scheme (NDIS), and our role as part of Victoria's existing quality and safeguarding mechanisms during the transition to the full NDIS. Further information about our contributions is provided in Appendix 1 (see page 55).

Submissions and reports

In 2015–16, we responded to requests to provide formal feedback and reports on the:

- proposed amendments to the *Crimes Act 1958* in relation to sexual offences
- operation of the *Victorian Charter of Human Rights and Responsibilities Act 2006*
- Department of Justice and Regulation's Access to Justice Review
- proposed audit program and Victorian Auditor-General's Plan 2016–17.

Participation in national meetings of mental health commissioners and health complaints commissioners

We maintain regular liaison with other mental health commissioners in order to ensure our approaches are informed by best practice and to identify opportunities to collaborate and contribute to improving people's experiences of mental health services to support their recovery.

We also participate as a member of the health complaints commissioners' group to address common issues across jurisdictions, including approaches to complaints about mental health services. In 2015–16, this included meetings with representatives of AHPRA and health practitioner boards to review existing referral and protocols for dealing with complaints about individual health practitioners.

Education and engagement





Our role

Education and engagement are key functions for the Mental Health Complaints Commissioner (MHCC). *The Mental Health Act 2014* (the Act) requires us to ensure the process for making a complaint is available and accessible to all Victorians.

It also requires us to provide information, education and advice to mental health services about their responsibilities in responding to complaints. By undertaking education and engagement activities, we aim to ensure consumers, families and carers understand their right to make a complaint and are confident in raising their concerns with us, or directly with the service.

Our approach

Our approach is guided by consultation and feedback from consumers, families and carers and highlights the need for proactive strategies to address barriers to making a complaint.

Our work with services aims to support cultural change in the ways in which staff approach complaints, and to create environments where consumers, families and carers feel supported to speak up about their concerns and experiences. Our work also aims to build the capacity of services to provide effective responses to complaints and to resolve complaints in ways that support people's recovery and improve services.

In 2015–16 we completed a whole of organisation *MHCC education and engagement plan 2015–17* to guide our education and engagement activities. We also started the planning and implementation of a number of projects to meet our responsibilities to consumers, families, carers and services under the Act.

Overview of education and engagement activities

We delivered a number of education and engagement activities for consumers, carers, families, services and other stakeholders including:

- 40 education sessions reaching 1,911 people, including 36 presentations and training sessions for staff on effective responses to complaints
- 28 education activities reaching 606 people, including projects and sponsored events
- 28 consumer/carers engagement activities, including meetings and consultations to promote awareness, input and feedback on our work
- 70 stakeholder engagement activities, including meetings and consultations to ensure effective referrals and working relationships.

Promoting awareness and accessibility

In our first year of operation our education and engagement activities focused on raising awareness of our role and promoting our key messages about complaints. In 2015–16 we sought to build on this work by improving our accessibility and responsiveness to priority population groups. People within these groups may experience particular barriers and challenges in raising concerns about their experiences with mental health services.

We have aligned this work to *Victoria's 10-year mental health plan* and its goal to promote equitable access and safe and inclusive services for all people, including Aboriginal people, people with diverse sexualities and genders, people from culturally and linguistically diverse backgrounds, people from refugee and asylum seeker backgrounds, people with disabilities, and young and older people.

We implemented a range of targeted activities and are working on a detailed plan to engage with these groups over the next three years. In 2015–16, we undertook the following activities to progress our goal of promoting awareness, accessibility and responsiveness.

Aboriginal people

We recognise that Aboriginal people are at greater risk of poor mental health than the wider population. We also recognise that the history of institutional and personal discrimination and exclusion may impact on their access to quality mental health care, and that we can provide a useful avenue for redress when this occurs in public mental health settings.

In 2015–16, we completed an internal cultural audit and initiated consultations with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and the Victorian Aboriginal Health Service (VAHS) to develop the MHCC's whole of organisation approach to engagement. Through these initial consultations, we responded to invitations to present at VACCHO's Social and Emotional Wellbeing Workforce Conference and Improving Care for Aboriginal Patients Conference.

We also participated in consultations convened by DHHS on the development of a Victorian Aboriginal Health and Wellbeing Strategic Plan.

Developing effective engagement strategies and culturally responsive services for Aboriginal people will continue to be a strong focus for our work in the coming year.

People from culturally and linguistically diverse backgrounds

We recognise the barriers that people from culturally and linguistically diverse backgrounds may face in raising concerns about their experiences with mental health services.

In 2015–16, we consulted with multicultural organisations, including the Ethnic Communities Council, and worked closely with translating services to produce an information sheet on making a complaint in the top 15 languages used throughout Victoria. This information sheet informs consumers, carers and families from culturally and linguistically diverse communities about their right to make a complaint under the Act.

The production and distribution of these information sheets will provide the foundation for future targeted engagement activities with specific groups and communities, including people from refugee and asylum seeker backgrounds.



People who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI)

As a result of consultations with Gay and Lesbian Health Victoria (GLHV) and Transgender Victoria we updated our information sheet on the mental health principles and making a complaint to improve accessibility and the appropriateness of the content for people who identify as LGBTI. We made this resource available via our website, and promoted it via the GLHV and Transgender Victoria networks.

In addition to this work, on 31 January, Commissioner Lynne Coulson Barr and other members of our team joined the Victorian Public Sector contingent for Pride March, enabling us to support this event and raise awareness of our services among LGBTI communities.

Young people

We recognise the importance of engaging with young people in different ways to support them in building positive relationships with mental health services, and to raise awareness of our role and their right to speak up about their concerns. In 2015–16 we piloted a project that combined art and social media to achieve these goals. We launched The Different Faces of Mental Health during National Youth Week (8–17 April), providing consumers in three youth mental health services with the opportunity to create a mask symbolising their experience with mental health, and to speak up through a different medium.

We received a diverse range of masks from the 50 young people who participated in the project and we promoted images of these masks on Facebook, with descriptions from the young people on what their masks represented. This allowed us to reach hundreds of people through visits to our site, with many liking, commenting and sharing our posts.

A selection of masks will be displayed at the services and at our office to create an ongoing awareness of the project's purpose. We look forward to working with services on an evaluation of this work, which we will draw on to inform the delivery of the project in 2017.

People with disabilities

We worked with the Disability Services Commissioner and the National Disability Insurance Agency (NDIA) on promoting awareness of the role of the MHCC in dealing with NDIS funded supports provided by Mental Health Community Support Services.

We collaborated with the Disability Services Commissioner and the Commonwealth Ombudsman on the production of a combined information card on complaints about NDIS related matters, and the types of complaints handled by each office. We also presented at forums on complaints and the NDIS, which were held for consumers, families, carers and services.

We have also promoted awareness and accessibility of our office to people with disabilities through sponsoring events for International Day for People with Disability, and the launch of ArtAbility, an art exhibition delivered by Action on Disability within Ethnic Communities.

Education and engagement with consumers, families, carers, services and other stakeholders

We delivered a wide range of education and engagement activities for consumers, families, carers, services and other stakeholders on the role of our office, safeguarding rights, and effective approaches to resolving complaints.

These activities included 36 presentations at conferences, forums, meetings and events to a range of audiences within the mental health sector. Conferences included the following:

- TheMHS Conference 2015: Translating Best Practice into Reality
- Negotiating Good Health Conference (2015)
- 7th Australian Rural and Remote Mental Health Symposium (2015)
- VICSERV's Mental Health Conference: Towards Recovery (2016)
- 6th VMIAC Consumer Workforce Conference (2016).

At these conferences, and through other education sessions, we shared our insights into the types of issues and themes identified in complaints made to our office and complaints reported by services, and ways in which this information can be used to improve services and people's experiences. We also highlighted people's rights under the Act and the mental health principles, and how these apply to the provision of mental health services and the resolution of complaints.

Other education activities included sessions with consumer and carer advisory groups, and information stands at conferences and sponsored events. Further information about our education and engagement activities is provided in Appendix 1 (see page 55).

As part of our education and engagement plan, we have continued to participate in a range of forums and meetings with consumer and carer groups and services. Our participation helps to ensure our work is informed by issues identified by consumers, carers and families, and that we receive ongoing input and feedback.

In 2015–16 we undertook 28 consumer/carers engagement activities, and a total of 70 stakeholder engagement activities, including meetings and consultations to ensure effective referrals and working relationships. These included collaborative work with the new Independent Mental Health Advocacy service, and regular meetings with DHHS, the Chief Psychiatrist, Victoria Police, the Public Advocate, the Australian Health Practitioner Regulation Agency and other statutory bodies.

Development of training and resources on effective responses to complaints

We continued to communicate our key messages on effective responses to complaints and raise awareness of the four most common outcomes people seek when they make a complaint. These are known as the 'Four As' of complaint resolution: acknowledgement, answers, actions and apology.

In 2015–16, we developed and delivered four tailored training sessions on responding effectively to mental health complaints, reaching a total of 129 staff in metropolitan and rural services.

We also started developing an MHCC learning package, which will support our provision of training and resources to services on effective responses to complaints. Through developing this learning package we aim to build the capacity of staff in services to effectively recognise, respond to and record complaints and to create the opportunity for complaints to lead to improved outcomes for the individual and the service.

Our initial work on the learning package included incorporating the 'Four As' of complaint resolution and the mental health principles, and promoting the responsibilities of services under the Act. This work has been informed by consultations with consumers, families, carers and services on their experiences with complaints, and the input of an advisory group into the proposed format, content and focus of our learning package.

We plan to further develop our learning package, which will include producing video resources on the experiences of consumers and carers in making complaints, with a view to piloting in 2017.

Building foundations for our ongoing work

This year, our education and engagement work was firmly focused on building strong foundations and key enablers of our future work. The most important enabler is the MHCC Advisory Council, which we worked to establish in 2015–16 (see page 53). We also worked on the following key enablers:

Website redevelopment

We commenced a website redevelopment project to improve the accessibility and functionality of our site. Our new website is due to be launched in 2016–17, and will provide an important platform to support all of our functions and facilitate our education and engagement activities.

Social media strategy

Since commencing operations on 1 July 2014, maintaining a presence on social media has enabled us to reach a wide audience of consumers, families and carers. Social media provides us with a platform for keeping in touch with the views and needs of our stakeholders, and for sharing information, insights and stories that:

- help to reduce the social stigma of mental illness and the fear of making a complaint
- build consumer and carer confidence to speak up
- promote our accessibility and awareness of issues relevant to the mental health sector.

This year, we updated our social media strategy to reflect our renewed focus, which resulted in increased growth and engagement of our online communities. In 2015–16, our number of Facebook followers grew from 2,200 to 2,323, and our number of Twitter followers grew from 300 to 480.

Learning and growing our capability





Our team and structure

The Mental Health Complaints Commissioner (MHCC) consists of a diverse group of people with a wide range of skills and experiences.

Our team consists of people with lived experiences as consumers, family members and carers, as well as experience in a range of roles and settings in the mental health system, human rights and statutory bodies. We also include consumer and carer representatives on our interview panels when recruiting to the MHCC.

Our teams focus on four main areas of work, consistent with our functions under the *Mental Health Act 2014* (the Act):

1. Resolutions and Review
2. Specialist Advice and Investigations
3. Education and Engagement
4. Operations and Strategic Projects

In 2015–16, we reviewed and adjusted our organisational structure in order to maximise our capacity to meet the volume and complexity of complaints made to our office. These adjustments included the creation of a Deputy Commissioner for providing the necessary expertise and supporting the integration of the four key areas of our work.

We also developed the *MHCC business plan 2015–19* to ensure we are well positioned to perform our statutory functions and achieve our goals, as articulated in the *MHCC strategic directions 2015–19*. In accordance with our business plan, we continue to review and develop our processes and to improve the efficiency and effectiveness of our work.

In 2016–17, we will be completing a resource modelling exercise and review, which will help us to identify the resources and capabilities required to carry out our statutory functions into the future.

Our learning and development

To build on our experience and expertise, we undertook a broad range of professional development activities in 2015–16, including training in complaints resolution, recovery-oriented practice, intentional peer support, our legislative responsibilities and specific aspects of treatment in the Victorian mental health system and related services. All of our Resolutions staff are accredited under the National Mediator Accreditation System or are working towards accreditation. Our team members also continued to participate in regular reflective practice sessions to review their work and make improvements.

In 2015–16 we attended a number of sector events and conferences. Our attendance at these events helped to ensure our practice is informed by the perspectives and experiences of consumers, families and carers and the mental health sector, and that our approach takes into consideration specialist knowledge, clinical expertise in mental health treatment, and best practice. Events included The Mental Health Services' (TheMHS) annual conference, the VICSERV Towards Recovery Conference, the 7th Rural and Remote Mental Health Symposium, and the 6th Victorian Mental Illness Advisory Council Consumer Workforce Conference.

We also completed an internal audit on cultural safety for Aboriginal people to assess the existing cultural competence of our organisation and identify potential actions to take in response. In 2016–17, we will undertake training in cultural safety in Aboriginal health and work with the Victorian Aboriginal Community Controlled Health Organisation and the Victorian Aboriginal Health Service to turn the outcomes of the audit and initial training into a more detailed learning and development plan.

Evaluating our work

As part of our ongoing commitment to growing our capability, we implemented a number of evaluation processes for our work in resolutions and in education and engagement. These have included evaluation processes for specific projects such as The Different Faces of Mental Health youth engagement project, and for training and education sessions that we deliver.

We also launched a pilot program in June 2016 to seek specific feedback from people who have made complaints to the MHCC about their experiences with our office, and to trial the options of online surveys and telephone interviews. We will use our evaluation of the pilot program to improve our practices and processes, and to inform the development of a more comprehensive feedback survey and evaluation program.

Feedback about our processes and approach

In 2015–16, we responded to a number of concerns in relation to our processes, including concerns about the timeliness of our actions. For each case, we reviewed our approach and considered whether we could have improved the way in which we handled the complaint. As part of the review, we endeavoured to speak to the person who had raised the concerns, and, where appropriate, we apologised to them for delays in progressing their complaint. We also responded to requests for information from the Victorian Ombudsman in relation to complaints about the MHCC that were made to their office.

We welcome the feedback that we received from consumers, families, carers and services. As a result of feedback received in 2015–16, we implemented changes to improve our processes and approach. These changes include clarifying processes for when staff are on planned or unplanned leave, and providing guidance to staff about requesting documentation from services. We have also made a number of changes to improve the timeliness of our actions.

Establishment of the MHCC Advisory Council

A key priority in 2015–16 was working towards establishing the MHCC Advisory Council.

Our Council will provide an opportunity for consumers, carers, families and people working in services to provide advice and have input into areas such as:

- the needs and priorities of people with lived experience in relation to complaint processes and effective responses
- key messages and strategies to address barriers to making a complaint
- communication materials, including brochures, education products and other resources
- communication channels, including our website and social media sites
- education and engagement strategies and projects, including training and resources on effective responses to complaints and complaint resolution
- ways of evaluating the impact and effectiveness of our work
- emerging issues in the sector that relate to our work, such as strategic projects or further research to promote service improvements
- review and development of our strategic plans.

As at 30 June 2016, the recruitment and selection process for the inaugural MHCC Advisory Council was underway, with plans for the Council to commence operation in August 2016. We look forward to the significant contributions that our Council will bring to learning and growing our capability.

Appendices



Appendix 01:

Presentations, events and activities

01. PRESENTATIONS

Conferences

The Mental Health Services (TheMHS) Conference
2015: Translating best practice into reality
Health Services Liaison Association (HSLA)
Negotiating Good Health Conference
7th Australian Rural and Remote Mental
Health Symposium
Victorian Mental Illness Awareness Council (VMIAC)
6th Consumer Workforce Conference
Victorian Aboriginal Community Controlled Health
Organisation (VACCHO) Social and Emotional
Wellbeing Workforce Conference
VACCHO Improving Care for Aboriginal
Patients Conference
VICSERV Mental Health Conference: Towards recovery

Forums

Australian Nursing and Midwifery Federation Victorian
Branch Mental Health Forum
Alfred Health Community Mental Health Service
Recovery Forum
Forum for services on complaints and the National
Disability Insurance Scheme (NDIS)
Forum for consumers, carers and families on
complaints and the NDIS
Office of the Public Advocate Forum for Mental
Health Community Visitors
Queensland Mental Health Commission The Virtue
of Complaints forum
International Mental Health Leaders Program
Indonesian Visitors Forum
Department of Health and Human Services
(DHHS) Operations Central Divisional Forum

Mental health services/sector events and meetings

Independent Mental Health Advocacy (IMHA)
induction program
Mental Health Tribunal meeting for full and
part-time members
Mental Health Tribunal information session for staff
Mental Illness Fellowship (Wellways) training session
for helpline workers
DHHS Carer Partnership Dialogue forum
DHHS senior leadership meetings for clinical mental
health services
DHHS senior leadership meetings for Mental Health
Community Support Services
DHHS senior leadership meeting for Child and
Adolescent Mental Health Services /Children and Youth
Mental Health Services
Community Managed Mental Health Leadership and
Management Program
Australian Borderline Personality Disorder Foundation
information evening
St Luke's Anglicare meeting for consumers and carers
CoHealth all staff mental health services forum
CoHealth session for youth mental health services staff
Melbourne Clinic Post Graduate education session
DHHS Expanding post discharge support initiative,
information session for health services
Other stakeholder events and meetings
Australian Health Practitioner Regulation Agency
training session for staff
Ethnic Communities Council of Victoria Health Policy
Committee meeting
Health Services Liaison Association (HSLA)
Committee meeting
MHCC learning package stakeholder meeting



02. TRAINING SESSIONS

- HSLA training session on responding to mental health complaints (Melbourne)
- HSLA training session on responding to mental health complaints (Shepparton)
- Monash Health Southern Community Mental Health Services team training
- Eastern Health Central Community Mental Health Services team training

03. EDUCATION ACTIVITIES

- The Different Faces of Mental Health youth engagement project implementation with Dandenong, Frankston and Bendigo Youth Prevention and Recovery Care Services
- Mind Community Conference information stand
- VICSERV Mental Health Conference information stand

04. SERVICE VISITS AND MEETINGS

- Austin Health and Mind Australia Prevention and Recovery Care Service visit
- CoHealth City Central visit
- Neami CEO and Victorian State Manager
- ACSO CEO and State Manager
- Mental Illness Fellowship (Wellways) CEO and Executive Team
- Eastern Health CEO and Executive

05. CONSUMER AND CARER ENGAGEMENT ACTIVITIES

- VMIAC meetings and forums
- Tandem meetings and forums
- DHHS Consumer Partnership Dialogue forum
- DHHS Carer Partnership Dialogue forum
- Orygen Youth Health Parkville - Youth Week activity and visit
- CoHealth - Youth Mental Health Services consumer meeting
- Action on Disability within Ethnic Communities ArtAbility awards
- Monash Health Mental Health Week Art Competition awards
- Health Issues Centre forums and consultations

06. CONTRIBUTIONS TO CONSULTATIONS AND PROJECTS

- The University of Melbourne Symposium on Community Treatment Orders
- DHHS Your experience of service mental health survey
- Victoria's 10-Year mental health plan
- The University of Melbourne Empathy and Portrayal of Mental Illness Workshop
- Victorian Health Reform Summit on *Health 2040*
- Proposed legislation for advance care planning
- DHHS Risk Assessment and Management Panel proposals on information sharing in relation to family violence risk management
- Aboriginal health and wellbeing strategic plan*
- DHHS Critical Client Incident Management System
- Office of the Chief Psychiatrist review
- NDIS quality and safeguards transition arrangements
- Victorian child safe standards and reportable conduct scheme implementation
- DHHS Compliment and Complaint Management Policy, Complaints Privacy and Integrity Unit
- Victoria Legal Aid translated brochure *Are you on a treatment order?*
- DHHS Victorian Health Incident Management System (VHIMS2) project

07. SUBMISSIONS AND REPORTS

- Feedback on proposed amendments to the Crimes Act 1958 in relation to sexual offences
- Report on the operation of the Victorian Charter of Human Rights and Responsibilities Act 2006
- Feedback to the Department of Justice and Regulation's Access to justice review
- Feedback on the proposed audit program and Victorian Auditor-General plan 2016-17

08. PARTICIPATION IN ADVISORY AND REFERENCE GROUPS

- Monash University, The University of Melbourne and DHHS Supported Decision Making Project
- Open Minds Advisory Board for the Victorian Public Service
- DHHS Participation Advisory Committee for the *Doing it with us not for us policy*
- IMHA Reference Group
- Second Psychiatric Opinion Advisory Group

Appendix 02:
Operations

FINANCIAL STATEMENT FOR THE YEAR ENDED 30 JUNE 2016

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 2015-16 according to DHHS accounts is provided below.

OPERATING STATEMENT FOR THE YEAR ENDED 30 JUNE 2016

Expenses from continuing activities*

Expenses	
Salaries and on costs	\$1,943,066
Contractors/External services	\$526,522
Supplies and consumables	\$534,447
Total expenses	\$3,004,035

*Includes expenses from activities carried forward from establishment

STAFFING

15.5 FTE as at 30 June 2016

16 staff positions, plus contractors engaged to perform specified functions and assist the MHCC to respond to the volume and complexity of complaints.



Appendix 03:

Compliance and accountability

Privacy and Data Protection Act 2014 and Health Records Act 2001

The Mental Health Complaints Commissioner (MHCC) 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 www.mhcc.vic.gov.au

Freedom of Information Act 1982

Requests for access to documents held by the MHCC, 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 MHCC 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 MHCC 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 MHCC 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 www.ibac.vic.gov.au

**Speak up.
Your
experience
matters.**

We welcome your feedback about your experience with us or any aspect of our work.

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

www.mhcc.vic.gov.au

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