



Mental Health
Complaints
Commissioner

Annual Report 2017





26 August 2017

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 2016–17.

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

Dr Lynne Coulson Barr
Mental Health Complaints Commissioner



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Commissioner's message

This year we welcomed the increased attention on safety and quality in health services as a result of the *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality Of Care* report.¹ The themes and findings of the report reinforce the importance of the safeguarding, oversight and service improvement functions introduced by the *Mental Health Act 2014* (the Act), including the role of the Mental Health Complaints Commissioner.

We use complaints to identify quality and safety issues, and drive positive change and improvements in individual mental health services and the system as a whole. Many of the initiatives we have taken since the establishment of our office align with the recommendations of the *Targeting Zero*¹ report.

At the heart of our work is a focus on people's right to receive mental health treatment in ways that support their recovery, and in accordance with the requirements and principles of the Act. The right to be safe, and to feel safe, while receiving treatment and care is fundamental to everything that we do.

We initiated our first major strategic project in 2016–17, with the support of the Department of Health and Human Services (DHHS). The project focuses on sexual safety in inpatient units and will consider the themes from four investigations conducted by our office in 2016–17, as well as an analysis of complaints where issues of sexual safety have been identified. The project considers the range of initiatives that have been undertaken to date and seeks to inform further actions to ensure sexual safety in inpatient units.

Complaints about people's experiences of feeling unsafe or being subject to incidents in inpatient environments indicates that more work is needed to recognise and address risks to people's sexual safety in these environments, and prevent such incidents and associated harms from occurring. The sexual safety project and related investigations, will be finalised in 2017–18, and will include recommendations to mental health services, the Chief Psychiatrist and the Secretary of DHHS on ways of addressing this important safeguarding issue.

We have continued to work with services to identify opportunities for improvement in assessing and resolving the range of complaints received in 2016–17. Over the past year, 73 service improvements were recorded as outcomes of complaints, with actions taken to address quality or safety issues. We also made four recommendations to the Secretary of DHHS to address systemic risk and safety issues identified through investigations conducted by our office.

In 2016–17, we introduced individual reports to mental health services to promote the use of complaints data to identify quality and safety issues. We have also been working with services to use these reports to identify opportunities for service improvements. These individual complaint reports — and the analysis of MHCC complaints data compared to local complaint reporting data — assists services to consider the extent to which they are supporting a culture where people feel confident in raising their concerns directly with the service.

Our education and engagement work continues to focus on: addressing the potential barriers and fear people may experience in making a complaint; supporting effective local resolution of complaints; and promoting the role of complaints in safeguarding rights, supporting people's recovery and improving services.

In 2016–17, we responded to an increasing number of requests from the sector to share and discuss quality and safety issues in mental health services as identified from complaints. We presented at national forums, psychiatry colloquiums and Masters of Psychiatry courses, and also contributed to a range of sector consultations and projects.

The establishment of the MHCC Advisory Council in 2016 has supported our commitment to co-production by providing a genuine opportunity for people with lived experience of mental health issues, families, carers and people working in services to shape and participate in our work. We are very fortunate to have attracted a diverse group of passionate and dedicated individuals under the leadership of our inaugural Chair, Anthony Stratford, who together bring deep insights to our work and share our goal of effecting positive change.

Our team delivered these activities and initiatives while responding to a continued high demand. Our office received 1,756 new enquiries and complaints in 2016–17. We were able to improve our rate of early resolution and achieve positive outcomes and actions in the majority of closed complaints. We continue to work on ways to maximise our capacity and effectiveness in responding to the volume and complexity of complaints made to our office, drawing on feedback from surveys and engagement activities to find ways to improve.

I give special thanks to the MHCC staff for the passion, care and dedication they bring to the important work of our office. Each day, we are reminded of the gravity and very personal nature of the issues that are raised with us, and the high levels of distress that people contacting our office may be experiencing. We are mindful of the importance of ensuring that people feel heard and respected and that their concerns have been taken seriously. We acknowledge the positive and timely engagement of staff in services who respond to issues raised with our office; and the support of consumer, carer and advocacy organisations in working with us to achieve improved outcomes from complaints.

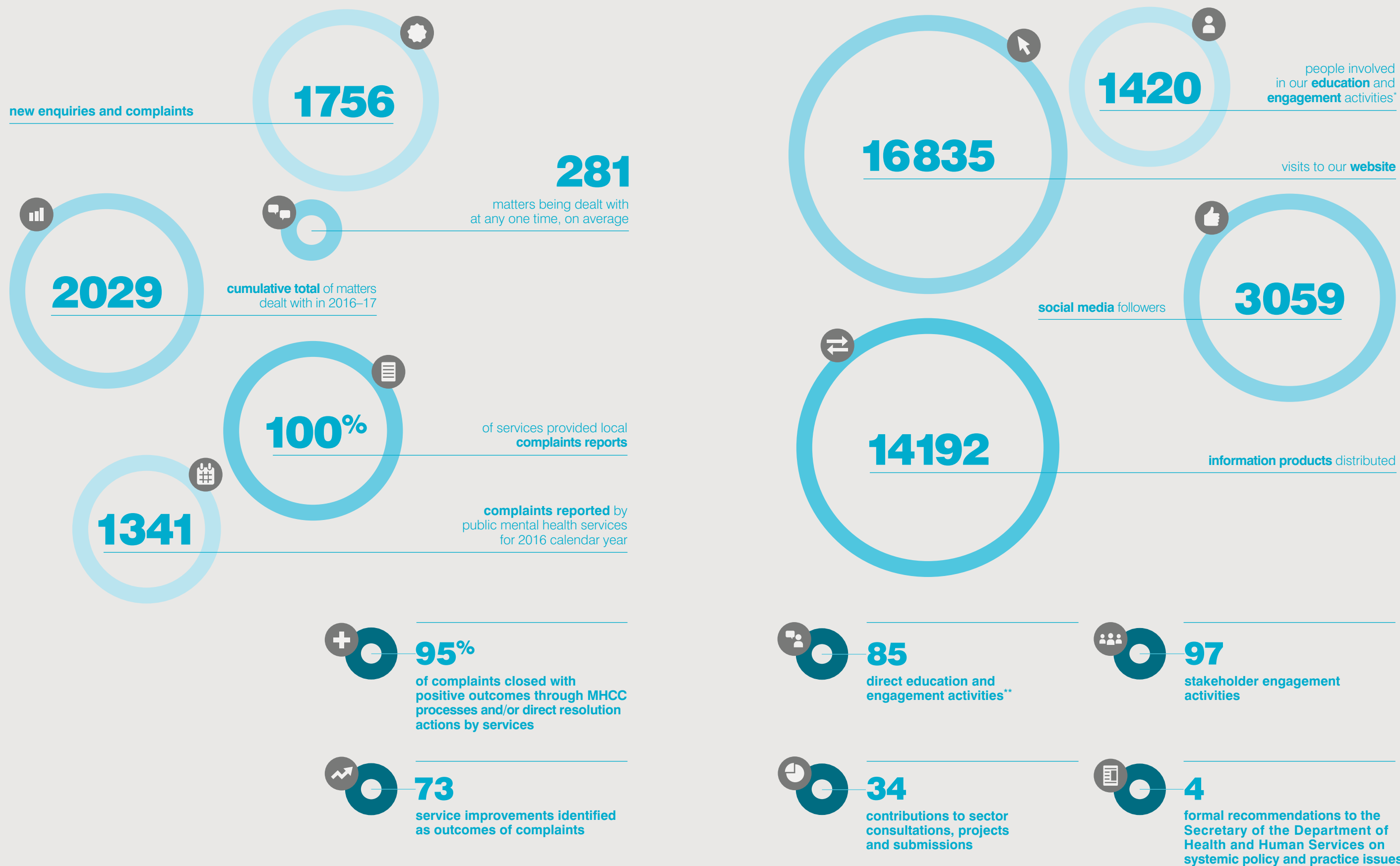
I thank the Hon. Martin Foley, Minister for Mental Health, and the Secretary of DHHS for their strong support and commitment to the role of our office. I also acknowledge the DHHS officers who support our operations, the Office of the Chief Psychiatrist, Clinical and Executive Directors of services, our colleagues in other statutory bodies and the many committed community members, and consumer and carer organisations who continue to support us as we grow and develop as an organisation.

This collective effort is essential to achieving the vision of a service system where consumers are at the centre of their treatment and care, and where complaints are seen as integral to safeguarding people's rights and improving the quality and safety of mental health services for all Victorians.

Dr Lynne Coulson Barr

¹ *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality Of Care* Report of the Review of Hospital Safety and Quality Assurance in Victoria October 2016, State of Victoria

Year at a glance



* Including consumers, families, carers, service staff and other stakeholders

** Including presentations, training sessions and other direct engagement activities



About the Mental Health Complaints Commissioner



A NOTE ON LANGUAGE

We recognise that a broad range of views and preferences exist concerning appropriate language to describe people who have lived experience of mental health issues.

Feedback from people with lived experience, consumers, families, carers and service representatives has guided our use of language in this report, and in our broader communications.

Throughout this report, we use words and terms that are consistent with those that appear in the *Mental Health Act 2014* (the Act). Where appropriate, we use person-centred, recovery-oriented, inclusive language.

COMMON WORDS AND THEIR MEANINGS

Consumer: a person who has accessed mental health services

Services / public mental health service providers: designated mental health services and publicly-funded mental health community support services

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, community, residential, 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.

The Mental Health Complaints Commissioner (MHCC) is an independent specialist statutory body, established under the *Mental Health Act 2014* (the Act) to safeguard the rights of people receiving public mental health services, resolve complaints, and recommend service improvements. We work collaboratively to resolve complaints in ways that support recovery and wellbeing, and improve services for all Victorians. We use what we learn from complaints to drive positive change, and work to ensure that complaints lead to improvements in the safety and quality of mental health services.

Legislative background

The MHCC was established under the Act in response to community feedback that identified the need for a complaints body that was independent, could provide specialised processes for people raising concerns about mental health services, and could drive improvements in the safety and quality of those services.

A fundamental 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 a key component of the safeguarding, oversight and service improvement mechanisms that were introduced to ensure rights are protected and the mental health principles set out under the Act are upheld.

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 must also inform the consumer when we close a complaint. Wherever possible, we seek to involve the consumer in the resolution of the complaint as early as 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 having regard to the legislative framework.

Our role and approach

We support consumers, families, and carers to raise their concerns or make a complaint directly to the service or our office. We provide accessible, tailored and flexible resolution processes, both informal and formal, that respond to the unique needs of people receiving mental health services.

We receive and analyse data from public mental health services about the complaints they receive and the outcomes of these complaints, and we work with services to address the issues we identify. Our team strives to build the capacity of services to develop a positive complaints culture, where services provide effective responses to complaints and people feel supported to speak up about their experiences and concerns. Where appropriate, we encourage and support early, local resolution of complaints between the person and the service.

We also undertake investigations into serious matters involving risk and safeguarding concerns identified in complaints where we assess this is appropriate. We make recommendations for service and system improvements, and use our range of powers and functions under the Act to effect positive change.

We uphold the mental health principles and ensure people's rights are promoted and safeguarded. By providing avenues for people to raise their concerns, to be actively involved in resolution and decision-making processes, and to have their experiences heard and respected, we play a vital role in improving people's experiences and supporting their journey towards recovery.

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 mental health principles

The mental health principles must be upheld by mental health services and 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)).

- People receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred.
- 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.
- 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.
- People receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.
- People receiving mental health services should have their rights, dignity and autonomy respected and promoted.
- People receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.
- 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.
- Aboriginal people receiving mental health services should have their distinct culture and identity recognised and responded to.
- 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.
- Children, young people and other dependents of people receiving mental health services should have their needs, wellbeing and safety recognised and protected.
- Carers (including children) for people receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible.
- Carers (including children) for people receiving mental health services should have their role recognised, respected and supported.



Advisory Council

CO-PRODUCTION

Co-production is an approach to working that involves the people who use a service in the design, development and delivery of that service.

Our commitment to co-production means that we seek to improve the experiences of people using our service by providing genuine opportunities for people with lived experience of mental health issues, families, carers and people working in services to shape and participate in our work.

The MHCC’s Advisory Council was established in 2016 to facilitate opportunities for people with lived experience, including consumers, families, carers and people working in services, to shape and participate in our work. The role of the council is aligned with Victoria’s *10-year mental health plan*, which recognises the importance of co-production at every level of service delivery.

- The MHCC Advisory Council members contribute their individual and shared knowledge, advice and input on areas such as:
- the needs and priorities of people with lived experience in relation to complaint processes and effective responses to complaints
 - key messages and strategies to address barriers to making a complaint
 - communication materials including brochures, education products and resources, website and use of social media
 - education and engagement strategies and projects such as training and resources on effective responses to complaints and complaint resolution
 - ways of evaluating the impact and effectiveness of the MHCC’s work
 - emerging issues in the sector relevant to the work of the MHCC, such as strategic projects or further research to promote service improvements
 - review and development of the MHCC’s strategic plan.

Planning and consultation

The planning and establishment of the MHCC Advisory Council was informed by extensive consultation and contemporary approaches to co-production. This was done through Senior Officers with lived experience undertaking the work and involving and engaging consumers, carers and staff in all aspects of the establishment, recruitment, and implementation of the Advisory Council.

Consistent with Victorian Government appointment and remuneration guidelines², we recruited a diverse membership that includes people of different gender and sexual identities, cultural and linguistically diverse backgrounds, youth representation and built in a weighting of people with lived experience as consumers. The position of Chair is reserved for a person with lived experience, who co-chairs the meetings with the Commissioner.

The development of recruitment materials focused on accessible and clear language and the distribution of these documents through established mental health services, consumer and carer networks was well received with more than 80 applications submitted.

The inaugural MHCC Advisory Council

- The first MHCC Advisory Council meeting was held on 17 August 2016. The council has met five times during 2016–17 to discuss a range of topics such as:
- key strategic projects, including the sexual safety project (detailed in the *Promoting service and system improvements* section of this report, page 41)
 - ways of evaluating the MHCC’s effectiveness and impact, including analysis of current complaints data, and outcomes of the MHCC’s pilot feedback survey
 - education and engagement projects and events including website redevelopment, consumer youth art project, Mental Health Week, and social media policy
 - education and engagement materials including videos, annual reports, and highlight documents.
- The council took part in a facilitated session to explore the purpose and goals of the group, deepening and sharing their understanding of what each council member brings and can contribute, mapping and sharing backgrounds, knowledge and expertise. This process allowed the council to identify potential gaps and future challenges, which laid the foundation for effective and productive future meetings.
- The MHCC’s Advisory Council membership includes:
- four people with lived experience as consumers including the Chair and a youth representative
 - three people with lived experience as family members/carers
 - three people with experience of working in mental health services.
- Provisions have been made to include a further youth representative and members who identify as Aboriginal and/or Torres Strait Islander, and to identify ways in which the input from diverse mental health priority population groups can be facilitated.
- MHCC Advisory Council members were appointed for an initial one-year term and have now accepted an extension of membership until 17 August 2019.
- Current members:
- Chair – Anthony Stratford
 - Annette Mercuri
 - Christine Abdelmalek
 - Gloria Sleaby
 - Hanna Jewell
 - Paula Fernandez
 - Rachael Lovelock
 - Robyn Callaghan
 - Simon Katterl
 - Dr Steven Moylan

2 Department of Premier and Cabinet, *Appointment and Remuneration Guidelines* 2016



Safeguarding rights and resolving complaints

Safeguarding rights

The Mental Health Complaints Commissioner (MHCC) has a responsibility under the *Mental Health Act 2014* (the Act) to identify, analyse and review quality, safety and other issues arising out of complaints, and to make recommendations to improve services.

Foundational to our approach is the principle that people receiving mental health services have the right to both be safe and feel safe during the course of their treatment, particularly in inpatient units.

The requirements, rights and mental health principles of the Act and the rights contained in the Victorian *Charter of Human Rights and Responsibilities Act 2006* (Charter) further set the foundation for our approach to resolving complaints. We consider how our complaints resolution processes can support and safeguard the rights of people receiving mental health services, and how these rights can be embedded at the heart of service practice.

By taking a rights-based approach to resolving complaints, we work to empower people who contact us to know and act on their rights through the complaints process and in their future experiences with mental health services. We also work with services on how they can better identify and uphold the rights of consumers, and how they can embed the requirements and principles of the Act in the day-to-day operation of the service. Finally, we acknowledge our role in holding services accountable for promoting and protecting the rights of consumers, and in keeping people safe while they are in their care.

We work with services, the Chief Psychiatrist, the Department of Health and Human Services (DHHS) and other relevant statutory bodies, to share information about safeguarding to ensure that services are safe for the people who use them. Through the complaints process, we identify and make recommendations to ensure people's rights are respected and promoted. We also draw on our analysis of issues relating to people's rights and safety raised through individual complaints.

In 2016–17, we commenced our first major strategic project to consider safeguarding issues raised through complaints to our office, and identified in local complaint reporting data provided by services. We identified a number of complaints where issues of sexual safety within acute inpatient unit environments were raised, either directly to our office or to services, and we commenced a project to examine the themes, and safety and quality issues arising from these complaints.

This strategic project will inform recommendations to mental health service providers, the Chief Psychiatrist, and the Secretary of DHHS on ways to ensure sexual safety in acute inpatient mental health services. This work will be finalised in 2017–18.



THE MENTAL HEALTH ACT 2014

The Act enables the MHCC to use a variety of approaches in resolving complaints, depending on what is most appropriate for a 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.

Our approach

We assess every complaint with reference to the Act, with a particular focus on the mental health principles and ensuring rights are recognised, promoted and upheld.

We work to resolve complaints in ways that:

- **safeguard rights**, promoting awareness of people’s rights and compliance with the Act and the Charter
- **support recovery**, ensuring people are heard and respected and feel confident that their views and preferences have been appropriately considered
- **improve services**, ensuring compliance with the Act 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 concerns directly with the service
- **aim to prevent a recurrence of issues**, both for the individual concerned and for others.

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.

Wherever possible, we support the person and the service to work together to gain a mutual understanding of the issues and reach an early resolution.

We prioritise and escalate responses to complaints involving risk and safeguarding issues to senior levels both within the MHCC and within services. We seek to identify the causes of any failure to uphold rights, and make recommendations to prevent recurrence of these issues.

We seek responses from services confirming that they have implemented 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 investigate matters and provide recommendations to services for addressing quality and safety issues identified in 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 requirements and principles of the Act, the National Standards for Mental Health Services, National Safety and Quality Health Service Standards and other relevant standards and guidelines.

We seek to understand what has occurred, how it has occurred, and how similar incidents can be prevented in future both for the individual and for others. Through this process, we also seek to increase the ability of services to identify critical safeguarding issues and take appropriate action to promote and uphold the rights of consumers.

Example complaint

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

Jarred, a consumer of a mental health community support service, contacted our office by telephone with concerns regarding the withdrawal of support for his appointment with the Royal Commission into Institutional Responses to Child Sexual Abuse. Jarred spoke of the importance of receiving support for this appointment, the significant trauma associated with being a victim of childhood sexual abuse, and his experience of episodes of severe mental illness.

Jarred explained that the service had agreed to provide support for his attendance at the Royal Commission as part of his recovery and support plan, but that the service contacted him on the morning of the appointment and advised that a support worker was unable to attend the appointment with him.

Because Jarred expressed pressing concerns about the availability of support from the service, a member of our Resolutions Team immediately contacted the manager at the service. The manager advised that the service had offered two workers to provide telephone support during the day, and that the service understood that Jarred was provided transport and counselling support by the Royal Commission.

Jarred felt that this initial response and explanation by the service did not acknowledge the impact the cancellation of this support had on his mental health. He expressed concerns about the reliability of support that was available from the service and said that it was a very difficult time for him and he needed support from workers who knew him.

Jarred confirmed his complaint in writing and we requested a review and response from the service.

As a result of Jarred’s complaint, the service conducted an internal investigation of the matter. The service manager subsequently met with Jarred, apologised for his experience, and provided an explanation for the changes and decisions that had been made in relation to his supports. The staff and managers reflected upon their processes and practice, and the service developed a new work instruction outlining the process and requirements of supporting a participant through the Royal Commission and similar inquiries.

Jarred also received follow up support from the service and continues to use their services.

Jarred’s complaint was an important reminder to the service of the critical role that mental health services play in supporting the recovery of people who have experienced childhood sexual abuse.



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.

Overview

In 2016–17, the MHCC experienced a sustained high level of demand. We received 1,756 new enquiries and complaints about Victorian public mental health services, comprising 118 enquiries (7 per cent) and 1,638 complaints (93 per cent) (Figure 1).

Including the 273 cases that were carried forward from 2015–16, we dealt with a total of 2,029 matters in 2016–17, consisting of 1,890 complaints and 139 enquiries. As an average, 281 matters were open at any one time.

While overall matters dealt with were similar to 2015–16, we received proportionally more complaints and fewer enquiries in 2016–17. In 2015–16, we responded to 1,729 enquiries and complaints overall, comprising 20 per cent enquiries (340) and 80 per cent complaints (1,389) (Figure 2). The comparatively higher number of complaints to enquiries received in 2016–17 indicates an increased awareness of the role and function of our office.

We continue to work to balance the competing demands of providing timely responses to all complaints, especially those involving urgent safeguarding matters, while also undertaking detailed assessment and resolution activities for the complex and serious issues raised in many complaints.

Figure 1
breakdown of new enquiries and complaints to the MHCC in 2016/17



Figure 2
breakdown of enquiries and complaints to the MHCC in 2015/16



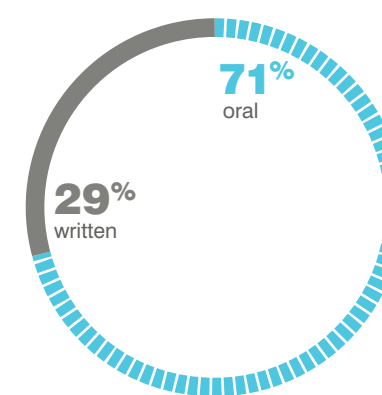
When we receive complaints from family members and carers, we discuss the options that are appropriate for their situation, including:

- 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.

Figure 3
how complaints were raised

base: all new complaints raised with the MHCC n = 1638



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 2016–17, the majority of complaints were oral: 1,164 of 1,638 new complaints (71 per cent), which is a similar proportion to 2015–16 (Figure 3).

The majority of oral complaints we receive relate to issues that are of immediate concern to the person contacting us. 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. Dealing with these complaints over the phone enables us to promote a responsive and timely resolution. It also allows us to facilitate a prompt response from the service, helping to support the person's engagement with their treating team.

When responding to oral complaints, we seek to clarify the person's concerns and gain their consent to contact the service to explore options for a direct response and 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 urgent risk and safeguarding issues that may need to be immediately escalated to the service to ensure actions are taken to safeguard the person's safety and wellbeing.

We also accept complaints where an early resolution process is not possible or appropriate, and we provide assistance to confirm complaints in writing where necessary. This assistance is most often provided where oral complaints involve safeguarding issues, or quality and safety concerns that require a formal response from the service. Formal responses are assessed by our staff with a view to both resolving the concerns and identifying improvements that will support better recognition and protection of rights, safety and better practice in future.

People who contacted us

Of the 1,756 new enquiries and complaints made to the MHCC in 2016–17, consumers raised 1,237 (70 per cent) and family members and carers raised 416 (24 per cent). The remaining complaints were made by advocates, legal representatives, friends and other services, or were referred from other bodies (Figure 4). This represents a slight increase in complaints made by consumers from 2015–16 compared to any other group, which is consistent with the pattern we saw in 2014–15.

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.

Figure 4
how cases were raised

base: new enquiries and complaints raised with the MHCC n = 1756

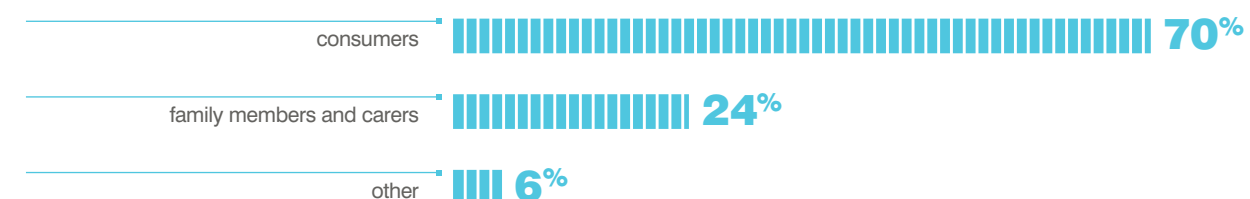
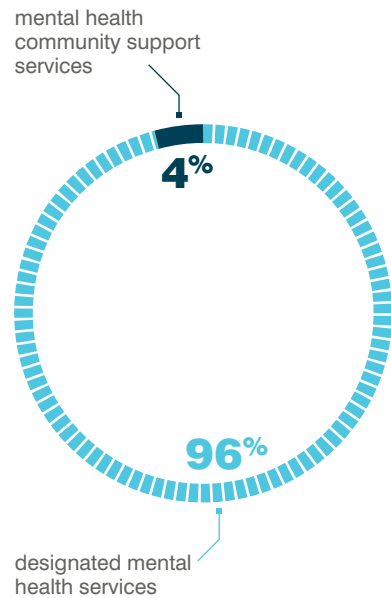


Figure 5
type of service provider
base: new enquiries and complaints raised with the MHCC where service provider was identified as either DMHS or MHCSS
n = 1442



Type of service provider

The 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 (MHCSS) (Figure 5).

This breakdown is similar to previous years, and the continuing higher proportion of complaints about designated mental health services is likely attributable to the higher numbers of consumers receiving treatment in designated mental health services, including compulsory treatment.

As an indicator, the proportion of registered consumers accessing designated mental health services is more than five times the number of registered consumers accessing MHCSS.³

Service program types

Of the new enquiries and complaints made to our office:

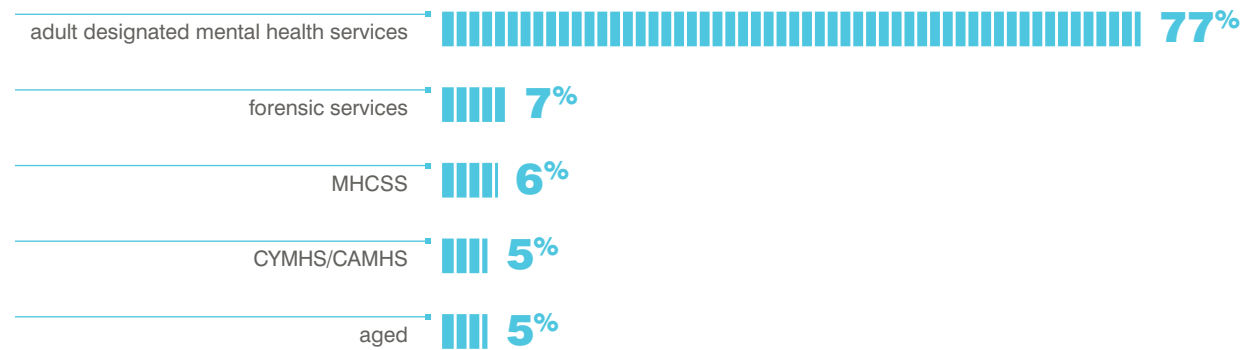
- 77 per cent were about adult designated mental health services
- 7 per cent were about forensic services (including services in prisons)
- 6 per cent were about mental health community support services
- 5 per cent were about aged mental health services, and
- 5 per cent were about children and youth mental health services (CYMHS) or child and adolescent mental health services (CAMHS) (Figure 6).

The proportion of complaints about aged mental health services and CYMHS/CAMHS are slightly lower than the proportion of consumers receiving these services, indicating the continued need for targeted education and engagement activities to promote awareness of the role of the MHCC in relation to these age groups.⁴

Fifty-eight per cent of matters raised about adult services related to inpatient services (including secure extended-care units and specialist inpatient services), 41 per cent related to community services (including community area mental health services or community care units) and the remaining one per cent related to other types of services.

Complaints about CYMHS or CAMHS services were equally divided between inpatient and community services, consistent with previous years.

Figure 6
service program types
base: new enquiries and complaints raised with the MHCC where service program was identified n = 1478



3 Calculations based on indicative numbers of registered consumers of DMHS and MHCSS in 2016 provided by DHHS.
4 As above. The *Education and Engagement* section of this report (page 47) includes more information.

While the number of complaints about aged mental health services was relatively small (75), the majority of these complaints were about inpatient services (84 per cent). As noted in last year’s report, there is some overlap in the jurisdiction between the Aged Care Complaints Commissioner (ACCC) and the MHCC with respect to mental health services provided in nursing homes and aged care services. In 2016–17, we worked closely with the ACCC to coordinate responses on a number of complaints about aged persons’ residential mental health services, which were also accredited aged care services.

The MHCC has jurisdiction to accept complaints from prisoners where services are provided by designated mental health services. Six per cent of all calls 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.

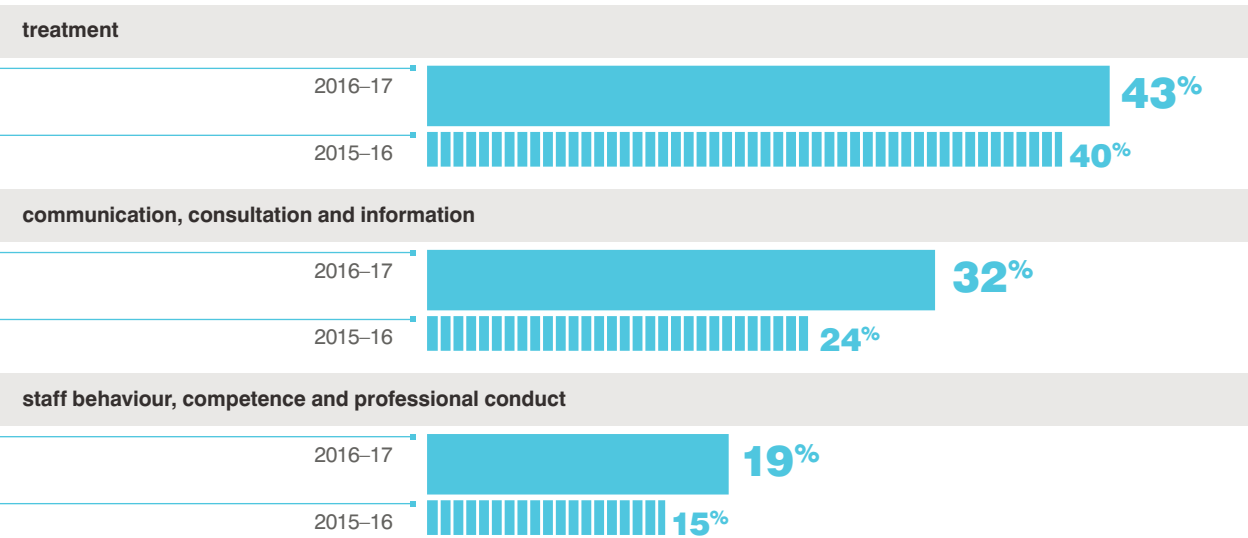
Key issues identified in all cases

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 continued to be the most common issue identified in new enquiries and complaints in 2016–17 (43 per cent). Consistent with 2015–16, the next most common issue was concerns about communication, consultation and information (raised in 32 per cent of new enquiries and complaints), followed by issues about staff behaviour, competence and professional conduct (19 per cent).

There were increases in the proportions of each of these types of issues compared to 2015–16, where treatment issues were identified in 40 per cent; communication, consultation and information issues were identified in 24 per cent; and issues about staff behaviour, competence and professional conduct were identified in 15 per cent of new enquiries and complaints (Figure 7).

Figure 7
main issues raised in new enquiries and complaints (2016–17 against 2015–16)



Other frequently occurring issues in 2016–17 included specific issues about medication (14 per cent), access to services (12 per cent), discharge and transfer arrangements (11 per cent), and environment, personal safety and management of the facility (eight per cent).

All these issues are consistent with those identified in 2015–16, except medication. This is likely due to a change in our classification of complaints, rather than an increase in concerns about medication, as this previously appeared as a significant subset of concerns raised about treatment.

We have previously identified, and continue to note, that the common concerns raised about treatment, communication and staff behaviour suggest there is a need for services to work on ways to better support people to exercise their rights to make and participate in decisions about their treatment and care.

Treatment issues

Almost half of the complaints made to the MHCC related to wide-ranging concerns about treatment. The most common issues related to concerns about the decision to provide compulsory treatment, or the way this was conducted (20 per cent); or concerns relating to the adequacy or effectiveness of treatment (10 per cent), such as the extent to which their views and preferences in treatment, including those set out in advance statements or related to the use of restrictive interventions, have been taken into account.

While the Mental Health Tribunal reviews decisions about compulsory treatment, consumers often raise related issues with our office. These include concerns about whether, or how adequately, a consumer’s rights have been explained to them, the amount of information provided to them about their rights, timeliness of access to their records in preparation for a Tribunal hearing and adequate notice to families and carers of scheduled hearings.

Specific concerns raised about medication, largely related to concerns about how medication was prescribed (nine per cent) or administered.

Other treatment issues included:

- disagreements about a diagnosis or concerns related to a lack of explanation about a diagnosis
- concerns that treatment provided was excessive, particularly in relation to compulsory treatment
- concerns about how a treatment plan was developed or followed
- delays in admission or treatment.

Communication issues

The majority of complaints about communication related to inadequate information or communication being provided from the service to the consumer, family member or carer (14 per cent). A related but separate concern was inadequate inclusion of the consumer, family member or carer (including a nominated person) in decision-making (11 per cent).

This again points to the need for a continued focus on supporting services to identify and take action about their responsibilities under the Act to support a person to make, or participate in, decisions about their treatment, and to include support people such as carers, family members and nominated persons in this process. Effective communication is central to recovery-oriented practice and recognising and respecting the role of families and carers.

Other concerns included:

- concerns that incorrect or misleading information was provided
- concerns about the right to communicate as set out in the Act, and restrictions on the right to communicate.

Staff behaviour and conduct

Concerns raised about staff behaviour and conduct continued to focus on staff attitudes, including a perceived lack of empathy and respect in interactions with consumers and carers (six per cent). Related concerns about staff behaviour were also raised about lack of attention to the consumer’s individual needs (six per cent). These types of complaints highlight the need for services to look for ways to continually improve the therapeutic engagement of staff with consumers, families and carers and ensure that people feel heard, respected and at the centre of their treatment and care.

We continue to receive a small but concerning number of complaints which involve significant risk and safeguarding issues, such as alleged discrimination, neglect or assaults, some of which are associated with episodes of restrictive interventions such as bodily restraint or seclusion. We prioritise these complaints to assess any immediate risk or safety issues for consumers, and assess all complaints involving allegations of staff or practitioner misconduct for notification and referral to the Australian Health Practitioner Regulation Authority (AHPRA).

Our assessment and responses to these types of complaints also take into account the adequacy of immediate actions and investigations undertaken by the service, the status of any police involvement and review of the requirements of the Act and relevant guidelines which may apply to the particular issue.

Example complaint

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

Yasmin contacted the MHCC to raise a complaint about her son, Ahmet's, treatment and care. She expressed concern that her son had harmed himself during a recent admission to an inpatient unit and that the family had not been informed in a timely way. She also expressed concern that her son had been discharged prematurely from the inpatient unit.

After being discharged from the service, Ahmet was involved in a car accident and required an extended period of medical treatment and rehabilitation. Yasmin felt that Ahmet's accident occurred because he was unwell and had he remained in the service the accident may not have happened.

In responding to this complaint, we acknowledged the trauma experienced by both Yasmin and Ahmet. At the time of receiving the complaint, Ahmet was very unwell and was being treated for his injuries. We spoke with Yasmin and the treating team about contacting Ahmet regarding his mother's complaint and we were advised not to contact him at the time due to his significant injuries after the car accident.

We assessed that there were special circumstances for us to accept the complaint without contacting Ahmet for his consent. We however spoke with Yasmin about contacting Ahmet periodically during our resolution process. She advised that Ahmet was happy to receive updates about the progress of the complaint directly from Yasmin, and we confirmed that he did not want to be more actively involved in the complaints process.

In addition to assessing the circumstances and response to Ahmet's self-harm during his admission, we identified the need to address Yasmin's concerns regarding discharge planning and communication with the service. In assessing this complaint, we considered the mental health principles as set out in the *Mental Health Act 2014* that relate to involving carers in decisions about assessment, treatment and recovery wherever possible.

We facilitated a meeting between the service and Yasmin to discuss her concerns. The focus of the discussion was on treatment options, communication with families after a critical incident, and discharge planning. The meeting provided the opportunity for the service to hear and respond directly to Yasmin's concerns and to identify ways they could prevent similar experiences for others.

We reviewed the service's policies and procedures, identifying areas for improvement, and we confirmed the agreed actions that arose from the meeting.

As a result of the complaint, the service advised of a number of changes they had made to reviewing and responding to critical incidents to ensure appropriate escalation to senior management (including the Clinical Director), immediate notification to family members, and coordination of supports provided to both the consumer and the family. The service also advised that staff were attending ongoing training on open disclosure and ways of effectively engaging with families after a critical event occurs. The service identified the importance of considering the family's views about risks, concerns and the need for additional supports during the discharge planning process.

Yasmin told us that she felt her concerns were treated seriously and she was pleased that her complaint had resulted in changes that could make a difference for her family and for others.

Access to services

Concerns about access to services related to concerns about the assessment process and the refusal of service, including:

- refusal to admit or treat a person
- dissatisfaction with the assessment process
- inappropriate or inadequate service
- delays in accessing a service.

We note that concerns about access are complex and impacted by a range of factors including demand for services. In resolving complaints about these issues, we note the importance of services supporting people to access appropriate treatment and supports to address their needs, particularly where an inpatient admission is assessed as not appropriate.

Discharge planning

Concerns raised about discharge and transfer arrangements are most often related to inadequate discharge planning or premature discharge. Examples of these types of issues included situations where there were identified risks to a consumer's wellbeing and lack of consultation with families and carers about circumstances of discharge, and the types of support and follow up that would be provided to the consumer. Other concerns related to assessing families' and carers' ability to provide support, and lack of communication or consultation prior to discharge decisions being made, including suitable discharge destinations.

Issues about the adequacy of discharge planning can also often be identified as an underlying issue in concerns raised about the effectiveness of treatment provided by both inpatient and community mental health teams. Adverse experiences of discharge planning can have significant negative impacts for consumers, families and carers, particularly when a hospital admission has been associated with a first episode or a traumatic event. These types of issues have been the subject of recommendations to services and to the Chief Psychiatrist on the need for improved guidance on discharge planning to ensure it is consistent with the requirements and principles of the Act and best practice.

Environment, personal safety and management of facility

A range of concerns continued to be raised about people's specific experiences of inpatient environments and how these issues are managed. The most significant concerns raised with us were where people felt unsafe in these environments and where incidents of alleged abuse, assault, or intimidation by another consumer had occurred. We prioritise these complaints to assess any immediate risk or safety issues for consumers and the adequacy of actions and responses taken by the service.

These complaints raise significant issues in relation to people's right to be and to feel safe within services, including the Charter rights of liberty and security of person (s 21), humane treatment when deprived of liberty (s 22), and privacy (s 13). Some of these complaints related to specific concerns about sexual safety within inpatient environments and are discussed in further detail on page 32, and in the *Promoting service and system improvement* section of this report (page 41).

Example complaint

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

Toni contacted the MHCC about her concerns about staff behaviour and attitudes at the residential mental health service where she had been living for some time. Toni identifies as a Transgender woman, and she expressed concern that staff members at the service were not always using her preferred pronouns and were referring to her as “he”. Toni told us that she tried to approach staff to remind them to use female pronouns but felt she hadn’t been listened to and that her concerns were dismissed. Toni spoke of the negative impact on her mental health, and how these interactions with staff triggered depressive episodes and caused her to withdraw socially.

We acknowledged Toni’s right to have her gender identity recognised and respected. We assessed that Toni’s concerns related to the mental health principle under the *Mental Health Act 2014* that 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. Her concerns also raised Charter rights in relation to possible discrimination.

We talked to Toni about her attempts to raise her concerns directly with staff, and identified that her verbal concerns had not been recognised or appropriately escalated as a complaint within the service. We wrote to the service and requested a written response as it was important to Toni that her concerns were acknowledged at a senior level. We also requested that the service provide us with their relevant policies related to gender sensitive and LGBTI-inclusive practices.

Toni said she appreciated the letter from the service, which outlined the expected practices of staff and provided an apology for her experience. However, in our follow up with Toni, she advised her everyday interactions with staff had not changed and that some staff were still not using the appropriate pronoun.

We spoke to Toni and the service about ways in which her ongoing concerns could be addressed. We facilitated a meeting to assist Toni to talk in person to senior managers at the service about her experience and the impact it had on her mental health. The service acknowledged that Toni’s experience was not consistent with the service’s policies and expected practices, and outlined planned training of staff. The service agreed to work with Toni to develop new strategies to address her concerns, including ways of ensuring that new and casual staff were aware of her wishes and preferences.

Toni told us that she appreciated the opportunity to give the service a deeper understanding of her experiences and felt more confident after the meeting that the service would be addressing her concerns about staff behaviour and awareness of LGBTI-inclusive practices. The service advised that, since they had received the initial complaint, the senior staff had organised further gender sensitivity training for staff and would be seeking further feedback from Toni on ways of ensuring inclusive practices. We undertook to follow up with the service to ensure the changes had been implemented as an outcome of Toni’s complaint.

Overview of outcomes

In 2016–17, we dealt with 1,890 complaints (excluding enquiries), comprising 1,638 received during the year and 252 carried forward from 2015–16.

Of the 1,890 total complaints we dealt with during the year, 1,576 were closed, with the majority closed as oral complaints (68 per cent).

Fifty-one per cent of all complaints were closed within one week; a further 22 per cent were closed within one month, eight per cent within two months, and five per cent within three months. The remaining complaints required more than three months to close (Figure 8).

In 2016–17, there was a five per cent increase compared with 2015–16 in complaints being closed within one week, and an eight per cent increase in complaints being closed within one month. These statistics reflect the high number of oral complaints that we dealt with, and improvements in our capacity to use informal processes to achieve timely resolution for these complaints. The increased rates of early resolution and responses to complaints has been achieved through our continuing work with services in facilitating their direct resolution of complaints, and practice improvements to our own assessment and resolution processes.

On average, the MHCC dealt with 281 matters at any one time during 2016–17. This amount, however, increased to 323 complaints open as at 30 June 2017. The majority of the complaints open at 30 June 2017 (282) were written complaints in various stages of assessment or resolution, and included five matters undergoing investigation. Over time there has been an increase in the cumulative total of complex complaints being dealt with by the MHCC, with a greater proportion of these matters being carried forward into 2017-18 than previous years.

Figure 8
time taken to close complaints
base: all complaints closed by the MHCC n = 1576

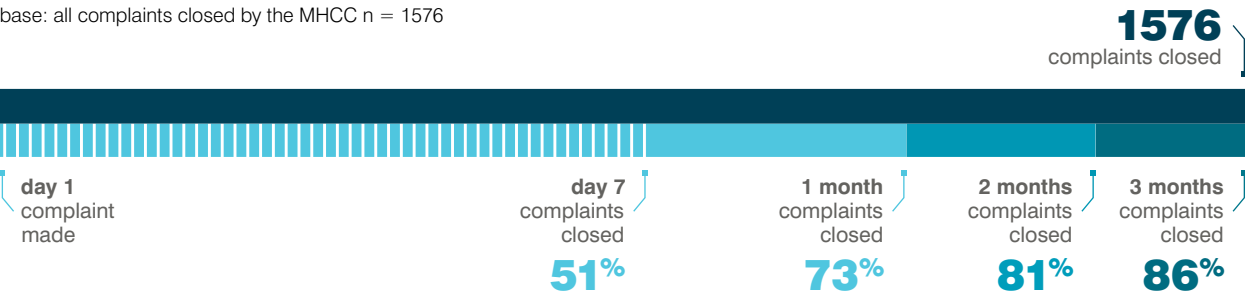
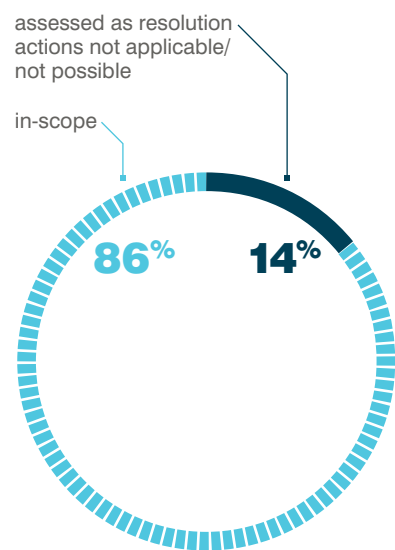


Figure 9
overview of outcomes
for closed complaints



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, there was no further contact from the person involved in the complaint, or because the complaint was outside the scope of the MHCC.

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.

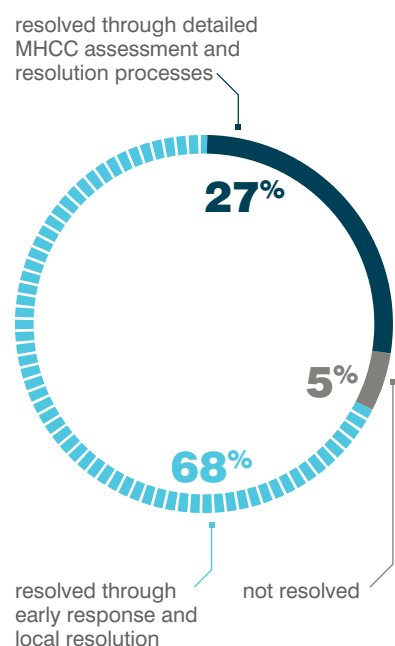
Of the 1,576 complaints that we closed in 2016–17, 1,361 were assessed as in-scope (86 per cent) and the remaining 215 were assessed as 'resolution actions not applicable/possible' (14 per cent) (Figure 9).

The proportion of complaints made to the MHCC that are in-scope for MHCC assessment and resolution actions increased five per cent (from 81 per cent 2015–16), this contributes to the increase in the cumulative number of complex complaints being dealt with by the MHCC.

Of the 215 complaints assessed as 'resolution actions not applicable/possible', 118 complaints were closed because the complaint was outside the jurisdiction of the MHCC due to timing (incidents that occurred prior to July 2013), 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 (15 per cent of complaints assessed as 'resolution actions not applicable/possible', equating to two per cent of all closed complaints).

Resolution outcomes

Figure 10
resolution outcomes for closed
in-scope complaints



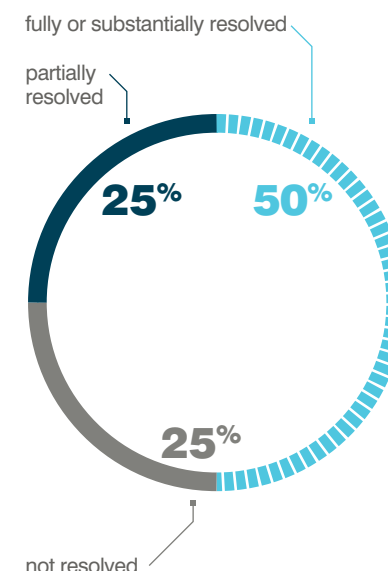
We achieved positive outcomes and actions by services in 1,289 of the 1,361 closed in-scope complaints (95 per cent). This was achieved either:

- through our office facilitating an early response and local resolution by the service (1,069 complaints representing 68 per cent) without the need for the complaint to be confirmed in writing and formally accepted by our office; or
- by the concerns being fully- or partially-resolved through detailed MHCC assessment and resolution processes (220 complaints representing 27 per cent) (Figure 10).

Seventy-two of the 1,361 closed in-scope complaints (5 per cent) were not resolved.

For the majority of the closed in-scope complaints where we facilitated early response and local resolution by the service, 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.

Figure 11
resolution outcomes for in-scope
complaints closed through detailed
MHCC assessment and resolution
processes



A NOTE ON OUR DATA

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' when reporting on these outcomes.

In the 292 in-scope complaints closed through detailed MHCC assessment and resolution processes, 50 per cent (148) were fully or substantially resolved, 25 per cent (72) were partially resolved, and 25 per cent (72) were not resolved (Figure 11). In the 220 closed in-scope complaints where concerns were fully or partially resolved through detailed MHCC assessment and resolution processes, we conducted comprehensive assessment of issues, and undertook detailed resolution processes, such as seeking and reviewing written responses and reports by services, and facilitating meetings and review processes.

In 2016–17, we closed a lower number of cases that were dealt with through our detailed assessment and resolution processes compared with 2015–16. This reduction does not represent an overall reduction in the amount of matters our office has dealt with using these processes. As at 1 July 2017, 282 complaints were still open and being dealt with in various stages of detailed assessment and resolution. This number of open cases reflects the increase in complex complaints received by our office in 2016–17. These cases require longer-term action, more follow up with services, and in some cases, investigation to ensure that the quality and safety issues have been addressed.

OUTCOME DEFINITIONS

Fully or substantially resolved

Complaints where 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.

Partially resolved

Complaints where 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

In these complaints there can be barriers, such as not being able to reach agreement on the outcomes sought by the person to address their concerns, to achieving a positive outcome. 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, for example, Victoria Legal Aid or community legal centres for legal advice.

How complaints were addressed and resolved: the ‘Four As’

When the outcomes of complaints were categorised into the ‘Four As’ of complaint resolution, 88 per cent recorded an action outcome, 42 per cent resulted in explanations or answers in relation to the issues raised, 39 per cent recorded acknowledgements by the service and 12 per cent resulted in an apology from the service (Figure 12).

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.

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.

Similar to last year, the most common actions to address individual concerns were:

- recognising and addressing communication issues between consumers, families, carers and services
- listening to consumers, families and carers concerns to clarify and respond to issues raised
- improving the way in which services or supports are provided to the consumer through discussion of possible ways to resolve individual complaints with service providers
- undertaking a review of documents including service policies to suggest or recommend practice improvements
- facilitating meetings between consumers, families and carers with service providers to effect outcomes from the complaint
- assisting individuals to prepare for meetings with service providers
- reviewing or developing the consumer’s treatment/recovery plan
- arranging access to a second psychiatric opinion
- providing or offering appropriate services.

- The most common types of service improvement actions were:
- making recommendations to improve policies and procedures to address concerns raised e.g. the need to provide and explain the statements of rights and the considerations under the Act on the right to communicate privately when an inpatient
 - recommending options for addressing specific complaints such as the use of restrictive interventions
 - identifying specific staff training needs, e.g. in using trauma-informed approaches.

We have been pleased with the ways in which services have identified opportunities for improvement and have confirmed a range of service improvement actions as outcomes of individual complaints.

In 2016–17, 73 service improvements were recorded across 30 complaints, with improvements proactively initiated by services, made as a result of discussions between the service and the MHCC in resolving the complaint, or as a result of formal recommendations made by the MHCC.

An overview of the areas addressed in our recommendations made to services under the Act is included in the *Promoting service and system improvement* section of this report (page 41).



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.

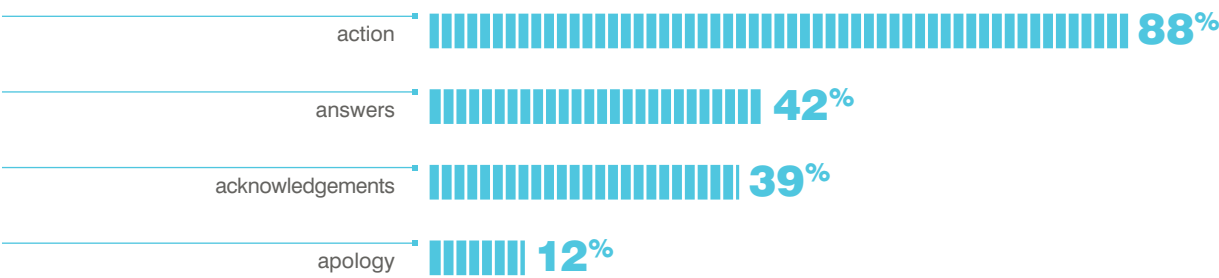
Action

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.

Figure 12
outcomes of complaints – ‘Four As’



Example complaint

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

Leya made a complaint to the MHCC about her experience in a specialist inpatient unit. She explained that she had reluctantly agreed to the admission and had sought reassurance from her treating doctor that her wishes and past negative experiences of treatment would be taken into account. She had prepared an Advance Statement and arranged for a Nominated Person to be involved in decisions about her treatment in the event that she became too unwell and was unable to participate.

Leya had a range of concerns about the treatment she received during her stay. She felt that the preferences detailed in her Advance Statement were not taken into account by the staff, and complained that the service did not include her Nominated Person in decisions about her treatment, care and recovery. In addition, she said that she felt isolated during her stay, and that there was a lack of group activities on the unit. Leya told us that she tried to raise her concerns directly with the service and was not provided with information about the complaints process. She said that staff discouraged her from making a complaint to the service.

After receiving Leya’s written complaint, we contacted her to discuss her experience in greater detail and the options to address and resolve her concerns. Leya said that she wanted her complaint to lead to improvements in the system for the benefit of future users of the service. She said that she had been physically and mentally unwell since her admission and was undergoing alternative treatment. As she was unable to participate in a meeting with the service at that time, she asked the MHCC to request a written response from the service.

We assessed that Leya’s complaint raised many questions about the consistency of the service’s practices with respect to the requirements and principles of the *Mental Health Act 2014* (the Act), particularly the principles of supported decision-making, promoting recovery and responsibilities in managing complaints.

The service provided a written response to Leya’s concerns, including an acknowledgment of her experience and an agreement that more direct involvement with her Nominated Person, and more regular engagement with Leya using her Advance Statement, may have improved her experience and recovery. The service also acknowledged that the group activity schedule was not operating during the time Leya had been an inpatient and that the service had since appointed a nurse to oversee the running of the group activity program in response to the complaint. The service apologised to Leya for her experience and thanked her for sharing her concerns.

We met with Leya and her Nominated Person to discuss their views about the answers, acknowledgements and apology provided in the service’s response. Leya said she wanted to hear more from the service about the actions they were taking to implement the improvements that her complaint had highlighted. She expressed an additional concern about the difficulty she had experienced accessing information about her right to a second psychiatric opinion during her admission.

The MHCC arranged a teleconference with the service to discuss Leya’s concerns and the questions that remained, and we requested more information about service improvement actions.

We talked with Leya and her Nominated Person about the further steps that could be considered as part of resolving her concerns. She said that although she did not want to participate in a meeting with the service, she agreed with our assessment that her experience had highlighted the need for further review of the service’s policies and practices. She was pleased that the MHCC decided to make a number of recommendations for service improvement actions as an outcome of her complaint.

We recommended that the service review staff training about the complaint process to ensure staff understood their role in acknowledging and responding to concerns raised by people on the unit. We also offered input on effective responses to complaints.

We recommended that the service review its process to ensure that a consumer’s Nominated Person is included in decisions about assessment, treatment and recovery and that a consumer’s Nominated Person is advised about decisions made, as required by the Act. The MHCC also recommended that the service review the use of Advance Statements to involve consumers in all decisions about their assessment, treatment and recovery and to be supported to make or participate in those decisions.

The service accepted all MHCC’s recommendations and agreed to engage with our office to provide advice and training about its complaints processes. We will continue to monitor the service’s implementation of our recommendations, to ensure that the experience of consumers is improved and that people’s rights under the Act are protected.

Investigations

After a complaint has been accepted, the MHCC has the power to conduct a formal investigation. We consider a range of factors when determining whether an investigation is appropriate, including the seriousness of the concerns, whether practice or systemic issues are raised that require a detailed review, and whether the issues are more appropriately investigated by another body, such as the Coroner, Chief Psychiatrist or Australian Health Practitioner Regulation Agency (AHPRA).

The Act authorises the Commissioner and appointed investigators to obtain information and evidence as part of an investigation, and requires the Commissioner to prepare a written report setting out the findings of the investigation and recommendations and actions for resolving the complaint. Services must respond to the report, and outline the steps taken or proposals to implement the actions and recommendations, within 30 business days.

Investigations commenced in 2016–17

As a result of receiving a number of complaints about issues of sexual safety in acute mental health inpatient environments, the MHCC initiated four investigations in 2016–17 in relation to complaints that occurred across four separate area mental health services.

A number of broad themes were identified across the four investigations, discussed in more detail in the *Promoting service and system improvement* section of this report (page 41).

As at 30 June 2017, the findings and recommendations of these four investigations were being finalised. The 2017–18 Annual Report will address the recommendations and outcomes of these investigations.

These investigations were undertaken as part of a broader project, commenced in 2016–17, to analyse and review safety, quality and other issues identified in complaints relating to sexual safety in acute mental health inpatient environments. More information about this project is included in the *Promoting service and system improvement* section of this report (page 41).

Investigations concluded in 2016–17

Our office began an investigation in 2015–16 that related to a serious adverse event in an inpatient unit, and associated issues about the adequacy of risk assessments, discharge planning, community care, responses to disability support needs and family and carer engagement.

As required by the Act, the service provided us with an action plan in 2016–17, responding to our recommendations. We have been working with the service to effectively implement the actions and recommendations.

A number of these actions aim to improve engagement and support of families and carers. The service has introduced a new process, including documentation of early warning signs and relapse prevention planning and development, to strengthen the provision of psycho-education to consumers, families and carers. The revised process will also assist clinicians to proactively seek information from families and carers so they can respond to concerns about a consumer's health, and ensure that the consumer's preferences about family involvement are documented and reviewed at regular intervals.

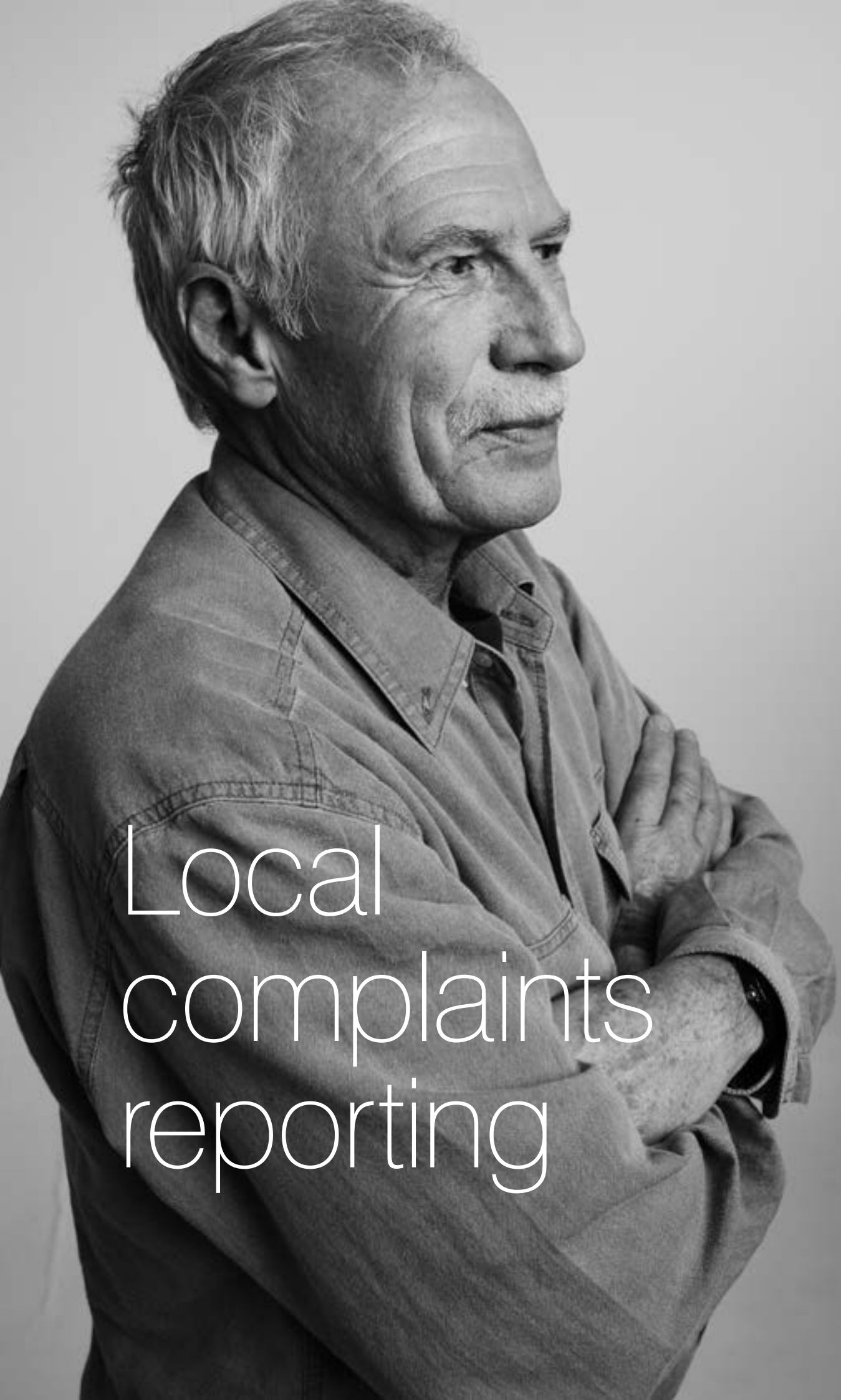
Further changes have been made to ensure that there is appropriate communication, such as with a general practitioner, particularly in relation to the prescribing of medication, where shared care arrangements are in place.

The service has made other changes to policies and procedures to strengthen its response to increased acuity levels and demand on the inpatient unit, improve discharge planning, enhance the recognition and protection of dependents as required by the principles of the Act (s 11(1)(j)), and optimise visibility in the inpatient courtyard. It will provide advice about making a complaint, including information about the MHCC, in 'information packs' offered to consumers, families and carers of inpatients.

In addition to making recommendations to the service, we made a number of recommendations to the Secretary of the Department of Health and Human Services as part of this investigation, as described in detail in the *Promoting service and system improvement* section of this report (page 41).

Our priorities

We continue to further develop our practices to improve the timeliness and effectiveness of our work in resolving complaints. We aim to increase services' ability to identify issues affecting people's rights, and to hold services accountable for promoting and upholding the rights of consumers, families and carers under the Act and the Charter. We will continue to work with services to identify areas for improvement and to recognise the service improvement work undertaken proactively by many services in response to complaints received both directly and to our office.



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.

Our approach

We collate and analyse this data, identifying key themes and emerging issues across the sector in order to inform projects and recommendations that lead to service improvements. We also use the data to provide insights into the concerns and experiences of consumers, families and carers, and the current status of complaint processes and reporting systems across the sector.

This year, for the first time, we distributed individual complaint reports to mental health services. These reports analysed complaints reported by services and those made directly to the MHCC, with a state-wide comparison of complaints. We have also made a number of visits, and started discussions with services to review this data together and to seek feedback about how we can refine and improve these reports. It has been positive to note that many services have engaged positively in these discussions and we welcome continued collaboration in the coming year. As we continue to analyse and discuss complaints reporting data with services, we hope to build a joint understanding of any trends and differences, to identify opportunities for improving the collection and use of the data, and to work together to achieve service improvement.

Last year, we noted the need to improve reporting about complaint outcomes and service improvements. This year, we aimed to progress this goal by providing more detailed instructions to services and offers of direct assistance to identify the appropriate outcome fields for extraction of data.

We also identified complaints where specific risk and safeguarding issues had been raised, and focused our efforts on obtaining complete outcome data for reported complaints that appeared to raise issues relating to sexual safety in inpatient units. This targeted approach aligns with the recommendation noted in the *Targeting Zero*⁵ report to use data to identify and investigate deficiencies in care.

We requested information from services about complaints where we identified potential concerns about sexual safety and the need to better understand the nature of issues raised and the actions taken by services. This information will be analysed as part of our 'sexual safety project' to inform potential recommendations for service improvements (more information about the sexual safety project is included in the *Promoting service and system improvement* section of this report, page 41). We may continue to request additional information in this manner where we identify themes and common issues in reported complaints, particularly when these issues raise risk and safeguarding issues.

⁵ *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality Of Care* Report of the Review of Hospital Safety and Quality Assurance in Victoria October 2016, State of Victoria

Observations about the data

Overall, complaints reported by services were significantly lower in 2016 than in 2015. However, complaints reported by MHCSS increased in 2016. Consistent with previous years, we continue to observe significant issues in data collection. These issues include inconsistency in the data provided and issues captured, and a lack of outcome data reported.

As in previous reporting periods, significant work was required to produce a consistent, combined data set that would enable meaningful comparison and analysis of the data. Given the concerns about data quality, we engaged an external research company to validate and conduct quality assurance processes on the data.

Over the coming year, we will continue to engage with services to understand the extent to which these data issues are due to reporting and recording issues with the current data collection system.

Contributions to the VHIMS2 improvement project

As in 2015–16, many of the challenges in local complaints reporting were associated with 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 2016–17, we continued to contribute to the DHHS VHIMS2 project, which aimed to improve the reporting functionality of the system and the data delivered. We made a number of recommendations for improvements including that:

- fields for recording complaint outcomes be given greater prominence, and that completion of complaint outcome be mandatory
- a field for recording service improvements be made available when complaints are closed
- categories for recording the relationship of the person making the complaint to the consumer be standardised across the system to ensure consistent recording
- mandatory capture of issues classification on every feedback item.

These recommendations are aimed at ensuring the MHCC is able to extract greater meaning from local complaints' reporting data, and more reliably use this data to:

- identify emerging themes
- identify quality and safety issues
- inform advice and recommendations by the MHCC on issues that may require further review or actions for service improvement.

These recommendations will be considered in the next stages of development of the VHIMS data set and reporting system, which is now being undertaken by the new Victorian Health Information Agency (VHIA). We will collaborate with the VHIA and DHHS with the aim of achieving a system that supports services to provide reliable and complete complaints data and the implementation of key recommendations of the *Targeting Zero*⁶ report.

⁶ *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality Of Care* Report of the Review of Hospital Safety and Quality Assurance in Victoria October 2016, State of Victoria



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 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 different approaches to categorisation of issues and outcomes may have affected the data.

We note that there are broad differences in the numbers of complaints reported by services, but caution should be used in interpreting these differences. 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 numbers and percentages of complaints made to the MHCC used in this analysis are for the period 1 January–31 December 2016, and therefore differ from those reported for the 2016–17 reporting period in this report.

Overview of complaints reported by services

This overview provides a comparative analysis of data from complaints made to services and to the MHCC for the period 1 January–31 December 2016. It compares numbers, service types, issues, sources of complaints and outcomes.

This year we achieved a 100 per cent compliance rate with all 35 organisations that provide public mental health services in Victoria submitting their complaints reports to the MHCC. While this was an improvement on the 92 per cent compliance rate in 2015, there was however a notable decrease in the total number of reported complaints.

Services reported a total of 1,341 complaints over the period 1 January–31 December 2016. This represents a pro-rata decrease of 12 per cent in reported complaints, in comparison to the total of 1,640 complaints reported by services for the period 1 January–31 December 2015. Our review of this data, and the quality of reports received, indicates that this decrease is most likely explained by issues in the recording and reporting of complaints by designated mental health services. The numbers of complaints reported by these services decreased in contrast to an increased number of complaints reported by the MHCSS.

We note that despite the increase in complaints reported by MHCSS, it is likely that the figures reported for both DMHS and MHCSS still represent an under-reporting of complaints made directly to services, particularly when the numbers of complaints per 1,000 consumers are considered as discussed below.

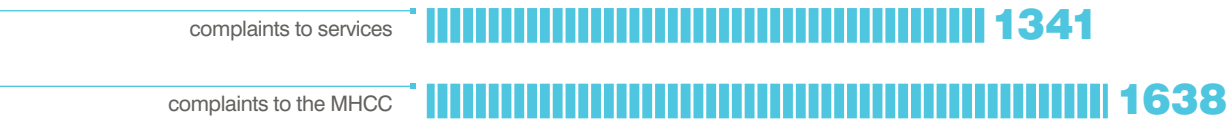
Reports were received from 19 DMHS and 16 MHCSS. Thirty-three of these organisations recorded at least one complaint, while two MHCSS provided a 'NIL return', indicating no complaints were recorded over the reporting period.

Complaints reported by services vs. complaints made to the MHCC

A total of 1,341 complaints were raised directly with mental health services during 2016 and reported to the MHCC ('reported complaints'), compared to 1,638 complaints made directly to the MHCC ('MHCC complaints') (Figure 13).

Over time, we aim to see a much higher proportion of complaints raised directly with services as a result of people being able, supported and confident to do so. This will rely on complaints being recognised, responded to and reported by services.

Figure 13
number of complaints raised with service providers and the MHCC
(1 January – 31 December 2016)



Complaints by type of mental health service provider

The majority of reported complaints were in relation to services provided by DMHS, with a smaller number of complaints made about MHCSS. A total of 1,099 reported complaints (82 per cent) were from DMHS, with 242 (18 per cent) from MHCSS. These proportions are similar to the differences in numbers of registered consumers receiving services from DMHS compared to MHCSS in 2016. In contrast, of the complaints raised directly with the MHCC, the majority were about DMHS (95 per cent), with far fewer about MHCSS (5 per cent), consistent with previous years. These differences may be partly explained by the different nature of services provided as discussed below under *'Issues raised in complaints'*.

While significantly more complaints were reported from DMHS than MHCSS, the data represents a decrease of 23 per cent in overall reported complaints by DMHS from 2015 from 1,467 to 1,099, and a corresponding increase of 40 per cent in complaints reported by MHCSS from 173 to 242 complaints. Over the coming year, we will be working with services to seek to understand the reasons for these differences and the extent to which they are due to reporting and recording issues with the current data collection system.

Complaints per 1,000 consumers

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.

According to data provided to the MHCC by DHHS, there were 65,237 consumers of DMHS and 11,552 consumers of MHCSS in 2016⁷. There was an average of 17 complaints per 1,000 consumers of DMHS compared to an average of 20 complaints raised directly with the MHCC. In comparison MHCSS reported an average of 21 complaints per 1,000 consumers compared to an average of six complaints raised directly with the MHCC.

Our meetings with services about their complaints data included discussion of the numbers of complaints per 1,000 consumers compared to similar services and sector averages, and ways of interpreting the data and apparent trends. We will continue to monitor these trends and seek to understand the reasons for the differences in the average numbers of complaints per consumers of DMHS compared to MHCSS.

⁷ Due to technical issues in data reporting systems, these client numbers should be treated as indicative numbers rather than validated totals. There is also an overlap of consumers receiving services from both DMHS and MHCSS and therefore an overall average number of complaints per 1,000 consumers could not be calculated.

Issues raised in complaints

The three most common issues raised in reported complaints related to treatment (29 per cent), staff behaviour or conduct issues (28 per cent) and issues about the environment and management of the mental health facility (22 per cent). This is largely consistent with 2015 trends.

It is worth noting that there are significant differences in the main issues reported by DMHS and MHCSS, reflecting the different nature of the services provided. For DMHS, the most significant issues were treatment, environment, personal safety and management of the facility, and staff behaviour and conduct. For MHCSS, the most significant issues reported were staff behaviour and conduct (nearly half of all issues), followed by communication issues, and treatment.

In contrast, 48 per cent of complaints made to the MHCC were about treatment issues, with communication issues (29 per cent) the next most common area of concern, followed by concerns about staff behaviour or conduct. These differences in the proportions and types of complaints are similar to those identified in the analysis of previous rounds of complaints reporting. There is a question about the extent to which concerns raised about treatment and communication by consumers, carers and families are being recognised, responded to and recorded as complaints given the significantly higher proportion of these kinds of complaints being raised with the MHCC compared with services.

We continue to observe that the themes of treatment, and staff behaviour and conduct in reported complaints suggest services need to consider ways in which the principles of the Act, particularly the right to make and participate in decisions about assessment, treatment and recovery, can be embedded into all aspects of treatment and care.

Service program types

Complaints reported by services were most commonly about adult mental health services (62 per cent). While this is a decrease from the 67 per cent reported in 2015, this is likely affected by the overall fall in complaints reported by DMHS.

Twelve per cent of reported complaints were about child and youth mental health services (CYMHS) or child and adolescent mental health services (CAMHS), which was similar to reported complaints in 2015.

Complaints reported about aged mental health services decreased from seven per cent of reported complaints in 2015 to five per cent in 2016. These proportions largely reflect the proportions of consumers receiving these services in 2016, but indicate a slightly higher rate of complaints about CAMHS/CYMHS compared to the proportion of consumers receiving these services (9 per cent CAMHS/CYMHS and 7 per cent aged mental health services).

As noted above, complaints reported by MHCSS increased from 11 per cent to 19 per cent of complaints in 2016.

In 2016, reported complaints were more or less evenly split between inpatient services and community services. This is an increase in the proportion of complaints made about community based services from 2015 (from 42 per cent) and is likely accounted for by the increase in complaints reported by MHCSS.

People who made complaints

Complaints made by consumers accounted for 64 per cent of reported complaints compared to 71 per cent of MHCC complaints, a slight increase from the 61 per cent reported in 2015. Family members or carers made 25 per cent of reported complaints, which is broadly consistent with 2015.

Five per cent of all reported complaints were complaints that were first made to the MHCC, a decrease from nine per cent in 2015. This is a positive sign that services are working on ways to encourage consumers, families and carers to feel confident to raise concerns directly with the service.

Complaint outcomes

Complaint outcomes were reported in 292 complaints to services (21 per cent), a reduction on the 430 complaints with reported outcomes in 2015 (26 per cent of reported complaints).

This is a significant issue for us to address with services, as they are required under the Act to include this information in their complaints reports to the MHCC. Robust and detailed outcome data is critical to help to build people's confidence in the impact of complaints in effecting broader system and service development. Last year, we identified that improving outcome reporting would be a key priority for 2016. To assist services to accurately report this year, we included detailed instructions in our reporting template for services. The continued low reporting of outcomes in 2016 demonstrates the need to continue to address this issue and support services in 2017 to improve their compliance with the requirement to report outcomes of complaints.

Our priorities

The *Targeting Zero*⁸ report highlighted the importance of using data to identify and investigate deficiencies in care. Local complaints' data is a valuable source of information that can identify areas requiring attention and improvement.

Accordingly, we continue to work with mental health services, DHHS and the new Victorian Health Information Agency on refining complaints reporting systems and processes. Doing so will enable us to maximise the value of the information provided through this process and identify and take action on areas that raise safeguarding issues. We will also continue to focus on refining and expediting our own complaint reporting processes and discussing complaint reports with services to build on the work commenced in 2016–17.

⁸ *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality Of Care* Report of the Review of Hospital Safety and Quality Assurance in Victoria October 2016, State of Victoria



Promoting
service
and system
improvement



We monitor and review responses to recommendations by requesting the service or DHHS inform us of actions taken, including sending copies of any subsequent revisions to policies or procedures. We then assess the response, and where necessary, request further information or provide advice about areas that may require further consideration.

Our role and approach

The Mental Health Complaints Commissioner (MHCC) has broad functions under the *Mental Health Act 2014* (the Act), to identify, analyse and review quality, safety and other issues arising out of complaints; and to provide advice and make recommendations for service and system improvements. We use the information that we gain from complaints to drive positive change, and to ensure complaints lead to improvements in the quality and safety of mental health services.

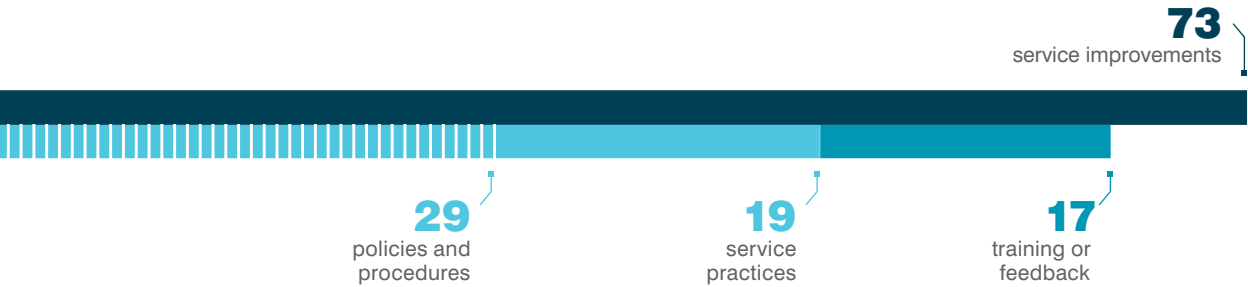
In 2016–17, we continued to work collaboratively with services to make a number of formal recommendations for change. We were pleased to see services proactively identifying and implementing practice improvements as a result of complaints made to our office. We also made a number of formal recommendations to the Secretary of the Department of Health and Human Services (DHHS), to address systemic policy and practice issues identified in complaints.

Service improvements through complaints resolution

In 2016–17, there were 73 service improvements recorded across 30 complaints. These improvements were: proactively initiated by services; made as a result of discussions between the service and the MHCC when assessing and resolving the complaint; or made as a result of formal recommendations made by the MHCC.

Of the 73 service improvements, most related to changes to policies and procedures (29), review of service practices (19), and training or feedback being provided to staff (17) (Figure 14).

Figure 14
service improvements



Policies and procedures

Recommendations and changes to policies and procedures covered a wide range of areas, including those relating to:

- the right to communicate and the use of mobile telephones in inpatient units
- the right to request a second psychiatric opinion and the requirements of the Act in relation to second psychiatric opinions
- the use of restrictive interventions, including ensuring debriefing and review following the use of a restrictive intervention
- responses to allegations of assault including supporting consumers to contact police
- changes to incident reporting procedures to ensure appropriate escalation of serious incidents
- discharge planning
- privacy and disclosure of information
- the right to make a complaint
- managing patient valuables during an inpatient admission.

Practices

Changes to service practice occurred in areas including:

- redesign of the specific elements of a service
- improved distribution of materials about patient rights
- improved record-keeping practices to ensure accurate records are maintained in relation to areas including complaints, restrictive interventions, medication management and compulsory status.

Staff training

Improvements relating to staff training including:

- supporting staff to recognise and respond to their responsibilities in assisting consumers and families to make a complaint (either directly to the service or to the MHCC)
- additional training for staff in medication management
- training staff to understand their responsibilities under the Act to support people to exercise their right to a second psychiatric opinion
- staff responses to particular presentations, including women in the perinatal period or people with a diagnosis of borderline personality disorder.

Other improvements

The remaining improvements primarily concerned changes to infrastructure, for example:

- installation of call bells
- improvements to the entry area of an inpatient unit to reduce the risk of absences without leave
- ensuring physical accessibility requirements are met
- the creation of women-only areas.

Service improvements through investigations

As a result of receiving a number of complaints relating to issues of sexual safety in acute mental health inpatient environments, the MHCC initiated four investigations in 2016–17 in relation to complaints that occurred across four separate area mental health services. Further detail about why these investigations were conducted by the MHCC is included in the *Safeguarding rights and resolving complaints* section of this report (page 12). As at 30 June 2017, the findings and recommendations of these four investigations were being finalised. An overview of the recommendations and outcomes of these investigations will be addressed in the 2017–18 Annual Report.

In the investigations work completed in 2016–17, a number of broad themes were identified and were raised in discussions with services about the preliminary findings of the investigations. These findings will inform detailed recommendations for service improvements to address areas such as risk assessments, effective communication with consumers about sexual safety, approaches to trauma-informed care, prevention and response strategies and the effectiveness of women's corridors and women-only areas in addressing the safety of women receiving inpatient care.



Sexual safety project

In 2016–17, with the support of DHHS, we commenced our first strategic project to analyse and review the safety, quality and other issues identified in complaints relating to sexual safety in acute mental health inpatient environments.

These issues range from reports of feeling unsafe in these environments, to incidents of sexual activity, sexual harassment and alleged assaults. This project will inform recommendations to mental health service providers, the Chief Psychiatrist and the Secretary of DHHS on ways to ensure the safety of people receiving mental health services.

This project will consider the findings of the four investigations undertaken in 2016–17 and an analysis of themes from complaints made to our office and local complaint reporting data where issues of sexual safety were identified. To support and inform the project, we have commissioned a review of literature and research on the causes and impact of sexual harassment and assault of people receiving treatment in acute mental health inpatient units, as well as evidence-based strategies to ensure sexual safety in those environments. We have also consulted with stakeholders including; consumers, carers, service providers, professional, peak and statutory bodies, and other governments agencies to build our understanding of the broad range of views and experiences of this important safeguarding issue. This work will also take into account the range of initiatives that have been undertaken to date to promote gender safety and gender-sensitive practices, such as staff training and the creation of women-only areas in inpatient units.

We have been encouraged by the level of interest and support for this project by all key stakeholders, and by work that individual services and the Chief Psychiatrist are carrying out to review relevant guidelines and practices. The recommendations of this project will seek to inform this work and future projects to ensure sexual safety in acute mental health inpatient environments.

Contributions to consultations, projects and advisory groups

We continued to contribute our experience and knowledge by taking part in a wide range of sector consultations and forums and engagement activities with key stakeholders. These activities also enable us to identify emerging themes and opportunities for service improvements, and contribute to broader initiatives at both a state and national level.

In addition, we responded to 19 requests to provide input into a number of key projects and consultations, including:

- Fifth National Mental Health Plan consultations
- Peer workforce developments and post-discharge support programs
- National Mental Health Commission Project: 'Equally Well National Consensus Statement' on the physical health needs of people with mental illness
- National Mental Health Commission Project: 'Housing, Homelessness and Mental Health' consultations
- *Victoria's 10-Year Mental Health Plan* Progress Measures Implementation
- NDIS Quality and Safeguards Arrangements for Transition in Victoria.

We also continued to participate in a number of advisory and reference groups to support related areas of work. In addition to continued participation on four key advisory groups, including the Second Psychiatric Opinion Advisory Group, we joined new advisory groups for projects on 'Working with Families and Carers', 'Building Mental Health Literacy and Capability in Ethnic Communities' and the Chief Psychiatrist's reference group on reviewing the sexual safety guideline.

Further information about our contributions is provided in *Appendix 1* (see page 62).

Submissions and reports

In 2016–17, we provided formal feedback on six matters, which included submissions to the Productivity Commission Review of NDIS Costs, and the Senate Joint Standing Committee 'Inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition'. We also provided formal feedback on the NDIS (Quality and Safeguarding Commission) Bill 2017, and the Victorian Ombudsman's own motion enquiry into the use of apologies in the public sector.

Participation in national meetings

We participate as a member of the Health Complaints Commissioners' group to address common issues across jurisdictions, including approaches to complaints about mental health services. We also maintain regular liaison with other mental health commissioners and in 2016–17, signed a formal Memorandum of Understanding to identify and support opportunities to collaborate and contribute to improving people's experiences of mental health services, recovery and wellbeing and key developments such as peer workforce and supports.

We joined the other mental health commissioners in the International Initiative for Mental Health Leadership Exchange held in Australia in March 2017, and shared service improvement initiatives with mental health commissions from other countries.

Recommendations to the Secretary of DHHS

In 2016–17 we made four recommendations to the Secretary of DHHS as a result of systemic issues identified through conducting investigations. We also continued to work with DHHS on a number of recommendations made in previous years. Many of these recommendations are currently under review and development with the Chief Psychiatrist. The recommendations we made in 2016–17 related to the areas outlined below.

Clinical guidelines for the management of shared care arrangements with private medical practitioners

The MHCC has identified the need for specific guidance for mental health services in relation to managing shared care arrangements with private medical practitioners including general practitioners. We have highlighted that these arrangements can be particularly problematic where consent is not provided to share information between the services, and where there is no other lawful basis for sharing information between services. We have recommended that the Chief Psychiatrist consider the need to develop guidelines to address this issue.

Courtyard design in acute inpatient units

The MHCC has identified courtyard visibility and lack of staff presence as a key risk factor for patients in acute mental health inpatient units. Accordingly, we recommended that DHHS consider setting standards and guidelines for the development of outdoor spaces in acute mental health inpatient units that provide a pleasant and therapeutic environment while also ensuring the safety of consumers.

Discharge planning

In a number of complaints, the MHCC identified discharge planning practices that did not effectively engage the consumer, family or carer, and where communication between service providers was poor. We have recommended that the Chief Psychiatrist be requested to review and expand current guidelines.

Access to disability services for mental health consumers and protocols for coordinated responses and care planning

We have identified a lack of specific protocols between mental health and disability services in relation to requests for access to services and coordinated care planning. The MHCC therefore recommended that DHHS developed a protocol and guidelines for disability and mental health services regarding access, assessment and coordinated care planning for mental health consumers who have disability support needs and include appropriate provisions for transitioning to the National Disability Insurance Scheme (NDIS).

We are pleased that the Secretary has noted these important issues and referred these recommendations to the Chief Psychiatrist for consideration and action. We continue to collaborate with the Chief Psychiatrist and DHHS on work being undertaken in response to recommendations made to the Secretary of DHHS outlined in our previous annual reports, and note the alignment of some of these recommendations with the important work being undertaken in response to the *Targeting Zero*⁹ report.

⁹ *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality Of Care* Report of the Review of Hospital Safety and Quality Assurance in Victoria October 2016, State of Victoria



Education and engagement

Our role and approach

The *Mental Health Act 2014* (the Act) requires the Mental Health Complaints Commissioner (MHCC) 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.

We work to ensure that people accessing mental health services understand their right to make a complaint and are confident in raising their concerns with us, or directly with the service. We also promote awareness of the rights and mental health principles of the Act. Our education and engagement work focuses on human rights, quality and safety, equitable access and inclusive services for all Victorians.

In addition to engaging with consumers, families and carers, we also work directly with services to support cultural change in the ways in which they respond to complaints. This cultural change requires services to support people to speak up about their concerns and experiences, and to see complaints as an integral part of treatment and care. We also support services to genuinely welcome complaints as a key avenue for reviewing practices and driving improvements.

To support this cultural change, our education and engagement work with services aims to build their capacity to provide effective responses to complaints, to make improvements and to resolve complaints in ways that support people's recovery.

In 2016–17, we continued to deliver to the MHCC's education and engagement plan (2015–17). We will be reviewing and updating this plan to ensure that we continue to focus our activities on work that supports our role and functions under the Act.



Overview of education and engagement activities and projects

In 2016–17, we delivered a wide range of education and engagement activities for consumers, families, carers, services and other stakeholders including:

19

education sessions

848

people, including:

- keynote presentations at conferences, forums and psychiatry colloquiums on quality and safety issues identified in complaints
- training sessions on effective responses to complaints.

16

targeted education and outreach activities

222

people, including:

- outreach projects
- information stands
- visits and meetings with services and consumer/carers advisory groups on complaint data and local complaint resolution processes.

50

consumer/carers engagement activities

345

people, including:

- the MHCC's World Mental Health Day event
- contributions to consumer/carers events and projects
- meetings and consultations to promote awareness, input and feedback on our work.

4

articles published in mental health journals and health publications, including:

- keynote presentations at conferences, forums and psychiatry colloquiums on quality and safety issues identified in complaints
- training sessions on effective responses to complaints.

97

stakeholder engagement activities on a wide range of areas to:

- support and develop our work
- ensure effective referrals and working relationships
- contribute to broader mental health service improvements and reforms.

3059

social media followers, with posts on key MHCC activities reaching close to

2000

approx. people per post, plus

16835

hits to the MHCC website

Promoting awareness and accessibility

In 2016–17, we continued to promote awareness of ways to raise complaints and the role of complaints in improving people's experiences. This included direct education and engagement activities, as well as engagement about MHCC activities and updates through our MHCC News e-bulletin, website news stories and regular social media posts.

We also continued to improve our accessibility and responsiveness to priority population groups, aligning 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. In particular, we focussed our efforts on engaging Aboriginal people, people from culturally and linguistically diverse backgrounds (including refugee and asylum seeker backgrounds), LGBTI Victorians, people with disabilities and young and older people. We recognise that people within these groups may experience particular barriers and challenges in raising concerns about their experience with mental health services.

Promoting accessibility and culturally competent services for Aboriginal people

Over the past 12 months, we have been working to increase engagement with Aboriginal Victorians and improve our understanding of what is needed to provide accessible and culturally competent services. We participated in the National Aboriginal and Torres Strait Islander Mental Health Forum, convened by the Australian Council of Health Ministers Advisory Group to identify priority strategies for services, governments and statutory bodies and commissions.

Our team undertook the Victorian Aboriginal Community Controlled Health Organisation's (VACCHO) Cultural Safety in Health training, and we continue to consult with both VACCHO and the Victorian Aboriginal Health Service to ensure the services we provide are culturally safe, inclusive and engaging. We also sought advice from VACCHO on the development and production of culturally appropriate and distinct information and resources for Aboriginal people in Victoria.

We acknowledge that there is a significant amount of work to do to achieve Indigenous health equality, and we are committed to continuing our focus on developing effective engagement strategies and culturally responsive services for Aboriginal people.

Respecting and recognising the experiences and needs of LGBTI Victorians

When people who identify as LGBTI experience discrimination and social exclusion, this can have a negative impact on their mental health and wellbeing, as well as their access to, and use of, health services. In 2016–17, we continued to promote our services and engage in activities that recognise and respect the experiences and contributions of people from Victoria's LGBTI community.

We actively contributed to the Tango Project, an initiative of Alice's Garage, sponsored by Victoria's Commissioner for Gender and Equality. This project seeks to address abuse and discrimination experienced by LGBTI Elders (members of the LGTBI community aged 65 years and older) on the basis of their sexual orientation, gender identity or intersex status.

In support of the Tango Project's aim to promote confidence and awareness of avenues to seek support and make a complaint, we joined with other Victorian commissioners, advocates and regulators to produce a video and participate in the *New Moves High Tea* event. This provided an opportunity for us to raise awareness about the role of our office and to increase our understanding and engagement with various networks within the LGBTI community.

In January 2017, for the second year running, we joined the Victorian Public Sector at the 2017 Midsumma Pride March, engaging with members of the LGBTI community and raising awareness and confidence in the role of our office. Our news story on the event, and image of MHCC team members taking part in a lively celebration of difference, acceptance and equality, resonated strongly with our social media followers.

Improving access for people from culturally and linguistically diverse backgrounds

In 2016–17, we promoted the availability of our information sheet on making a complaint in 16 different languages through the Department of Health and Human Services' (DHHS) *Health Victoria* magazine and *Primary Health News* e-bulletin. This built on our earlier work in providing multicultural service providers with packs of our new resources tailored to reflect the communities they work with, and making our resources available on the Victorian Transcultural Mental Health's website and the Health Translations Directory.

We also sought to increase awareness of our office through multicultural events hosted by the Mental Health Foundation Australia, and our participation in the ArtAbility project and awards event run by Action on Disabilities within Ethnic Communities (ADEC). Our series of social media posts on our involvement in Artability allowed us to reach more than 3,000 people on Facebook.

In recognition of the distinct cultural and linguistic needs of Victoria's diverse deaf community, we partnered with the team from Vicdeaf to produce two videos in Auslan (Australian Sign Language) that explain our work and provide information on the right to make a complaint. We have received positive feedback on these resources, including from Deaf Children Australia's CEO, Dean Barton-Smith AM.

Vicdeaf shared our new resources with key members of their team, including Vicdeaf NDIS Access Coordinators, and shared our social media posts to their sites. Vicdeaf also published our news story on their website, and raised awareness via their monthly e-bulletin, *Under the Gaslight*. With Vicdeaf's support, our resources reached more than 4,000 people on Facebook.

Engaging with younger people through art and social media

We recognise the importance of engaging with young people in different ways to support them in building positive relationships with mental health services.

In 2016–17, we built on our *Different Faces of Mental Health* pilot project that combined art and social media to engage with young people creatively and promote our key messages about complaints. This project was nominated for the 2016 ‘Leadership in the Public Sector Awards – Communication Award’ for its innovative approach to addressing the barriers young people may experience when raising concerns about access or treatment in public mental health services.

The project and the wall of powerful masks produced by young people featured in our World Mental Health Day event, along with a moving and inspirational presentation from Christine Abdelmalek, youth representative on the MHCC Advisory Council.

During National Youth Week 2017, we took part in the Mind Youth Forum, where young people from Mind Australia’s youth prevention and recovery care services (YPARCs) showcased masks they had created as part of the second stage of our project. The masks and messages that the young people shared, demonstrated the important role that art can play in a person’s treatment and recovery. Our social media posts on this initiative helped us engage with close to 2,000 people.



We participated in the painting of the faces and discussing the MHCC ... The resident group at Dandenong Youth PARC embraced the mask project because it was an activity that had no barriers. It didn’t matter that English may not be your first language or whether you could read and write. You didn’t need to have money to buy materials to participate. The masks are an outward creative expression of the inward reality. Young people have completed their masks during staff assisted sessions but many also chose to spend their own time completing the masks. We now have glitter from one end of the PARC to the other and creativity all round our art room.

MIND YPARC SERVICE

People with disabilities and the NDIS

In 2016–17, we worked with DHHS to produce information about the MHCC’s role as part of the Quality and Safeguards Transitional Arrangements in Victoria project. As part of these arrangements, new services approved to provide NDIS supports for people with psycho-social disabilities will be notified of the MHCC’s role and their obligations under Victorian legislation.

Over the coming year, we will continue to promote awareness of the MHCC’s role in dealing with complaints about NDIS funded supports provided by mental health community support services.

We also recognise the range of communication support needs of people with disabilities, and have consulted with an accessible communications expert to produce information on making a complaint in Easy English. This resource will be tested to ensure the accessibility of the information and will be released later in 2017.

Promoting awareness of the MHCC’s role with aged mental health services

In 2016–17, we engaged with the Aged Care Complaints Commissioner (ACCC) and the Commissioner for Senior Victorians to discuss ways to promote awareness of people’s right to make a complaint about their experiences with aged mental health services. We also collaborated on the Tango Project to engage with LGBTI Elders, as noted above.

Over the coming year, we will continue to work closely with the ACCC and the Commissioner for Senior Victorians, and will also be engaging with the Council on the Ageing (COTA) Victoria, to promote awareness and explore ways of addressing the barriers that older people, families and carers may experience in raising their concerns.

Education and engagement with 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.

In total, we reached 1,420 people through 85 direct activities undertaken in 2016–17.

Our activities included 15 presentations at conferences, forums and meetings to a range of audiences within the mental health sector, including:

- National Mental Health Reform and Innovation Conference
- Towards Eliminating Restrictive Practices 11th National forum keynote and dinner presentations
- Psychiatry Colloquiums and ‘Grand Rounds’ for senior staff at mental health services
- Psychiatric Registrars through the University of Melbourne Masters of Psychiatry course.

These presentations largely focused on:

- people’s rights under the Act, the mental health principles, and how these apply to the provision of mental health services and the resolution of complaints
- quality and safety issues identified in complaints to the MHCC and in local complaint reporting data
- the role of complaints in addressing avoidable harms and promoting service improvements.

In addition to presentations and training sessions, we delivered targeted education and outreach activities, which over the past year have included sessions with consumer and carer advisory groups, and meetings with senior staff to discuss themes in complaint data. These sessions have focused on supporting approaches to local resolution of complaints and the use of information from complaints to inform service improvements.

As part of our education and engagement plan, we undertook 50 consumer/carer engagement activities to promote awareness of our role and to ensure that our work continues to be informed by the issues identified by consumers, families and carers. These engagement activities included:

- forums and meetings hosted by the Victorian Mental Illness Awareness Council (VMIAAC) and Tandem (representing Victorian mental health carers)
- consumer-led projects that support recovery and celebrate diversity, such as the Monash Health Mental Health Week Art Awards and the Mojo Mental Health Short Film Festival.

In addition, we undertook an increasing number of stakeholder engagement activities in 2016–17 in response to emerging issues identified in complaints and new developments in the sector, these included:

- the NDIS Transitional Arrangements
- recommendations from the report *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care*
- regular meetings with DHHS, the Chief Psychiatrist, Safer Care Victoria, Victoria Police, Independent Mental Health Advocacy service, the Health Complaints Commissioner, the Public Advocate, the Australian Health Practitioner Regulation Agency and other bodies to ensure effective referrals and working relationships.

Development of training and resources

We continued to work with services to support them in developing effective responses to complaints. We also sought to raise awareness of the four most common outcomes people seek when they make a complaint, the 'Four As' of complaint resolution: acknowledgement, answers, action and apology.

We have further developed the content of our learning package, to incorporate the 'Four A's', and to focus on people's rights and ways in which effective responses to complaints can support recovery.

In 2016–17, we developed four engaging videos that will form part of a learning resource that will be adapted for different target audiences. These videos depict scenarios and experiences of consumers and carers, and were co-produced through the input and involvement of members of the MHCC Advisory Council. This approach ensured that the videos accurately reflect real and genuine experiences of consumers and carers of the types of issues raised in complaints, and the enablers and barriers to making complaints.

We have been invited to be part of DHHS' North Eastern Victoria Innovative Learning Training and Professional Development Cluster (NEVIL) program for mental health services in 2017 during which we will be piloting these materials.

Enablers for our work

Website redevelopment

We have progressed our website redevelopment project, seeking to improve the accessibility and functionality of our site. Our new website is due to be launched in 2017, and will provide an important platform to support all of our functions and facilitate our education and engagement activities. This site is being designed with key features to improve accessibility, including webpages translated into 15 languages other than English.

Social media strategy

Since starting operations on 1 July 2014, maintaining a presence on social media has enabled us to reach a wide audience.

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 2016–17, our number of social media followers grew from 2,820 to 3,059.



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 ranging from working in mental health services, law, social work, nursing, and dispute resolution. Many of our team members have lived experience of the mental health system as consumers, family members and carers.

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

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

Reviewing our operations and building capability

In 2016–17, we undertook a resource modelling exercise to identify the resources and capabilities required to carry out the functions of a number of statutory bodies. This work informed adjustments made to our organisational structure to maximise the effectiveness and efficiency of our operations, and the provision of resources to increase our capacity to undertake investigations and strategic projects on risk and safeguarding issues.

Our commitment to co-production

We strive to genuinely involve people with a range of lived experiences in the design, development and delivery of our processes (including resolution practices), projects and approaches. We align this work with *Victoria's 10-year mental health plan* which recognises the importance of co-production at every level of service delivery. We do this in a variety of ways, including:

- the MHCC Advisory Council (read more about our Advisory Council on page 10 of this report)
- recruitment processes with consumer and carer representatives on our interview panels
- targeted consultation in education and engagement projects, e.g. creative input and script development for the MHCC's new training videos
- extensive consultation at sector events and conferences.

Our learning and development

We undertook a broad range of professional development activities in 2016–17, including training in:

- complaints resolution
- recovery-oriented practice
- providing culturally safe services to Aboriginal Victorians
- our legislative responsibilities including the *Charter of Human Rights and Responsibilities Act 2006*
- specific aspects of treatment in the Victorian mental health system and related services.

All of our resolutions officers are accredited under the National Mediator Accreditation System in association with the Resolution Institute, or are working towards accreditation. Our team members participate in regular reflective practice sessions which provide an opportunity to reflect on issues and consider how practice can be developed and improved.

We also attend a range of sector events to gain an understanding of best practice, and to learn from others who have specialist knowledge and clinical expertise in mental health treatment. These events are listed in detail in the *Education and engagement* section of this report (page 47).

Continuous improvement through evaluation and feedback

We use the feedback we receive about our processes and approach to make changes to improve. We seek feedback in a range of ways including:

- informally, e.g. through our website and social media channels
- formally, e.g. through our external feedback survey and internal evaluations of work and projects
- through responding to concerns and complaints that people raise about their experience with us.

Seeking feedback about complaints processes

Feedback survey

In 2016–17, the MHCC introduced a formal feedback process, using a pilot survey with people who had made a complaint to seek their feedback about our approach. This process was time-limited, and recruitment for the survey was influenced by several factors including difficulty making further contact with people to seek their participation, resulting in a small sample size. The responses we received nonetheless contained valuable feedback about what we are doing well and where we could improve.

To improve response rates and offer more immediate and simple ways for people to provide feedback about their experiences with our office, we have reviewed and adjusted our approach to seeking feedback in 2017–18.

2016–17 feedback survey results

- 73 per cent of respondents found it easy to make a complaint
- 56 per cent of respondents said that their experience with the MHCC improved their confidence to make a complaint in the future
- We received strong positive feedback about our team's professionalism and helpfulness.

Reported satisfaction with our complaints process varied, and appeared to be closely associated with expectations of complaint outcomes. We will continue to refine how we measure people's satisfaction with our processes and consider our approach to communications to improve people's understanding of our role.

We will conduct a further survey in 2017–18, adapting our approach and expanding the survey to seek more detailed feedback about people's experiences with our office, and their expectations and views about complaint outcomes. We also continue to conduct internal evaluations of our resolutions and education and engagement work. These have included evaluation processes for specific projects, and for training and education sessions that we deliver.

Feedback about our complaints' process

In 2016–17, we responded to a number of concerns in relation to our processes, including concerns about the timeliness of our actions, the approach adopted, and decisions made. 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 usually requested a discussion with the person who had raised the concerns. We apologised where we identified that we should have taken a different or timelier approach, and sought to learn from each matter to improve our processes.

Where a person was dissatisfied with a decision we had made, for example, a decision to close a complaint, we reviewed the basis for our decision having regard to the person's feedback and any additional information available. In cases where we affirmed the original decision we provided a further explanation of the reasons for the decision and advised the person of the right to make a complaint about our decision to the Victorian Ombudsman.

We also responded to requests for information from the Victorian Ombudsman in relation to complaints about the MHCC that were made to their office.

Improving our processes and approach

We welcome the feedback that we received from consumers, families, carers and services through our survey and concerns raised directly with our office. As a result of this feedback, we implemented a range of changes in 2016–17 to improve our processes and approach. These improvements are outlined below.

Timeliness for complaints resolution

In 2016–17, we sought ways to reduce the average time taken to reach resolution by improving our support to our resolutions team to assist them to manage their significant complaint caseloads. For example, we have improved our case management system and introduced new reporting processes to help us identify complaints that require immediate action. We will continue to prioritise resources to our resolutions area, and to seek ways to streamline processes and improve our timeliness.

Improved contact with people making a complaint

In 2016–17, we considered ways to improve our contact and follow up with people who contacted our office, including introducing an email-to-text system which will provide an additional method of contact and allow us to provide short updates to people when we are unable to reach them on the telephone or by other channels. We will be implementing the email-to-text system in 2017–18.

Satisfaction with complaints about access and communication

Our survey indicated comparatively low levels of satisfaction from people making complaints about access to services and communication with their treating team. To address this feedback, we are seeking ways to provide support and information to our resolutions team on responding to these types of complaints, including reminders, guidance and discussion. We are also trialling an improved practice where complaints about communication issues are identified early and are progressed to a facilitated teleconference or facilitated meeting. Anecdotal feedback suggests this practice is leading to higher levels of satisfaction and we will be continuing to seek ways to improve satisfaction in this area.

Clarity about our role

We received feedback through the survey that indicated that our role and function is not always clear to the people who contact us. We are considering this feedback in terms of our external communications to ensure that we are clear about our role and what we are unable to accept as a complaint. For example, while the MHCC can assist to ensure a person's views and preferences about their treatment are considered, decisions about compulsory treatment are not within our scope.

Working with family members

In 2016–17, we introduced an expedited process for assessment and decisions on complaints made by family members relating to a person's death, including an early face-to-face meeting with the person making the complaint. In these cases we need to carefully consider the issues with regard to the jurisdiction of the Coroners Court to investigate the circumstances relating to the cause of death. An expedited process enables us to communicate our decision at the earliest possible opportunity.

Appendices

Appendix 01:
Presentations, events and activities

01 PRESENTATIONS

Conferences and forums

Gippsland Alcohol and Other Drugs and Mental Health Carer and Consumer forum

National Mental Health Reform and Innovation conference

Towards Eliminating Restrictive Practices 11th National forum

Towards Eliminating Restrictive Practices 11th National forum dinner

Presentations to mental health services/stakeholders

Australian Health Practitioner Regulation Agency (AHPRA) Victorian Medical Board

Alfred Health Psychiatry Grand Round

Health Services CEOs Department of Health and Human Services (DHHS) forum

Inner West Area Mental Health Service

Melbourne Health Mental Health Executive

Monash Health Psychiatry Colloquium

Peninsula Health Mental Health program

South West Health Care Consumer and Carer forum

South West Health Care Mental Health and Community Services Staff forum

St Vincent's Hospital Mental Health program

The University of Melbourne Psychiatry Colloquium

02 TRAINING SESSIONS

AHPRA staff training session on responding to mental health complaints

Monash Health Community Mental Health Team session on responding effectively to complaints

Office of the Freedom of Information Commissioner staff training session on responding to mental health complaints

University of Melbourne Master of Psychiatry course session on MHCC role and effective responses to complaints for Psychiatric Registrars

03 EDUCATION ACTIVITIES

Engagement with consumer and carer advisory groups on MHCC role and local complaints resolution

Albury Wodonga Area Mental Health Service Wangaratta Consumer and Carer Advisory Group

Inner West Community Mental Health Consumer Advisory Group

Inner West Area Mental Health Service Consumer/Carer Advisory Group information session

St Vincent's Hospital Mental Health Consumer Reference Committee

Information stands and outreach activities

Mental Health Foundation Mental Health Week launch event — information stand

Mind Community Conference — information stand

The Eastern Mental Health Service Coordination Alliance Workforce Development Committee, Eastern Metropolitan Region Orientation — information stand

Projects

Accessible resources in Australian Sign Language — videos created in collaboration with Vicdeaf

Culturally appropriate resources for Aboriginal people in Victoria — information sheet created in collaboration with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO)

The Different Faces on Mental Health — youth art engagement project in collaboration with Mind Youth forum, Dandenong, Frankston, Bendigo, Traralgon and Wodonga Youth Prevention and Recovery Care (YPARC) services

04 SERVICE VISITS AND MEETINGS ABOUT COMPLAINTS DATA AND THEMES

Alfred Health

Austin Health

Eastern Health

Inner South Community Health

Melbourne Health

Mind Australia

Monash Health

South West Healthcare

05 CONSUMER AND CARER ENGAGEMENT ACTIVITIES

Action on Disability within Ethnic Communities ArtAbility launch and awards

Consumer workforce engagement meetings with consumer consultants and peer workers

MHCC's World Mental Health Day event

MidSumma Pride March

Mind Youth forum

Mojo Mental Health Film Festival

Monash Health Mental Health Week Art Competition awards event

'New Moves' video and Seniors Week event for LGBTI Elders: Tango Project

Tandem meetings and forums

Travencore Norfolk Terrace Community Care Unit, IWAMHS Mental Health Week event

Victorian Mental Illness Awareness Council (VMIAC) Consumer awards presentation

VMIAC meetings and events

06 CONTRIBUTIONS TO CONSULTATIONS AND PROJECTS

Alfred Health Psychiatry Service Plan consultation

Auditor General's proposed audit on accessibility of mental health services

DHHS design, service and infrastructure plan for Victoria's clinical mental health system and review of transitional support services

DHHS health advocate position for Inner Gippsland

DHHS mental health workforce attraction campaign consultation

DHHS review of the effectiveness of the legislative framework for supported residential services

Fifth National Mental Health Plan consultations by Mental Health Australia

National Mental Health Commission project: 'Equally Well National Consensus Statement' on the physical health needs of people with mental illness

National Mental Health Commission project: 'Housing, Homelessness and Mental Health' Victorian workshop

NDIS Quality and Safeguards arrangements for transition in Victoria input and consultations

NDIS Quality and Safeguarding framework and legislation consultations

Office of the Chief Psychiatrist's proposed consumer rights project consultation

St Vincent's Hospital Post Discharge Support Program

Victorian Equal Opportunity and Human Rights Commission (VEOHRC) Strategic Plan consultation

Victorian Ombudsman's 'Enquiry into alcohol and other drug rehabilitation services post prison' consultation

Victorian Ombudsman project: 'Development of guidelines for dealing with challenging behaviour for complaint handlers' input and consultation

VMIAC rights poster project

Victoria's 10-year mental health plan progress measures implementation consultation

Wellways (MI Fellowship) advisory council consultation

07 SUBMISSIONS AND REPORTS

Productivity Commission review of NDIS costs

Senate Joint Standing Committee 'Inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition'

NDIS (Quality and Safeguarding Commission) Bill 2017 and consultation paper

Victorian Ombudsman's own motion enquiry into the use of apologies in the public sector

Victorian Ombudsman's request for information of provision of advice on right to complain to the Ombudsman

Report on the operation of the *Victorian Charter of Human Rights and Responsibilities Act 2006*

08 PARTICIPATION IN ADVISORY AND REFERENCE GROUPS

Chief Psychiatrist's review of guideline for promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units reference group

DHHS Mental Health Branch, Working with Families and Carers Project Advisory Group

DHHS Participation Advisory Committee

Independent Mental Health Advocacy (IMHA) Reference Group

Open Minds Advisory Board for the Victorian Public Service

Second Psychiatric Opinion Advisory Group

Tandem and VMIAC, Building Mental Health Literacy and Capability in Ethnic Communities Project Advisory Group

Tango Project Alice's Garage, Addressing abuse and discrimination of LGBTI elders reference group

09 OTHER STAKEHOLDER MEETINGS AND EVENTS

Aged Care Complaints Commissioner liaison and consultation meetings

AHPRA liaison and consultation meetings

AHPRA National Registration and Accreditation Scheme research summit

Australian Commission on Safety and Quality and Health Care liaison and consultation meetings

Australia and New Zealand Health Complaints and Disability Commissioners’ meetings

Australia and New Zealand Mental Health Commissioners’ meetings

Brook Red Mental Health Peer Work Conference

Commissioner for Children and Young People liaison and consultation meetings

Commissioner for Gender and Sexuality

Commissioner for Senior Victorians liaison and consultation meetings

DHHS and Victorian Managed Insurance Authority (VMIA) — Open Disclosure forum

DHHS Mental Health Branch — NDIS transition liaison meetings

DHHS Safewards forum

DHHS Secretary, Deputy Secretary and Directors liaison and consultation meetings

DHHS *Targeting Zero: Report of the review of hospital safety and quality assurance* briefing forum

Disability Services Commissioner liaison and consultation meetings

Health Services Commissioner/Health Complaints Commissioner liaison and consultation meetings

Health Services Liaison Association (HSLA) meetings

Independent Mental Health Advocacy (IMHA) liaison and consultation meetings

International Initiative for Mental Health Leadership Exchange

Launch of ‘Safe and Strong’ Victoria’s Gender Equality Strategy

Mental Health Foundation Multicultural Dinner

Mental Health Tribunal liaison and consultation meetings

Multicultural Commissioner, Youth Commissioner liaison meeting

National Aboriginal and Torres Strait Islander Mental Health forum

National LGBTI Mental Health and Suicide Prevention Strategy webinar launch

Office of the Chief Psychiatrist liaison and consultation meetings

Office of the Public Advocate (OPA) liaison and consultation meetings

Premier’s Award for Health and Medical Research 2017 event

Royal College of Australian and New Zealand Psychiatrist consultations on MHCC input to education programs

Safer Care Victoria liaison and consultation meetings

Safer Care Victoria/Victorian Health Information Agency, Better, Smarter Care: Reducing Unwarranted Variation conference

Stakeholder consultations for ‘sexual safety’ project

Supported Decision Making launch and forum — Monash University and University of Melbourne Australian Research Council Linkage project

The Melbourne University Disability Research Initiative 2017 forum

The University of Melbourne seminar on female-only mental health wards

VEOHRC Handling Human Rights Complaints Masterclass

VicHealth Prevention is Possible forums

Victorian Equal Opportunity and Human Rights Commission — liaison and consultation meetings

VMIA consultation meeting

Victorian Ombudsman liaison and consultation meetings

Victorian Public Healthcare Awards 2016

Victorian Women’s Honour Roll Ambassadors workshop and consultation

Victoria Police, Deputy Commissioner Capability liaison and consultation meetings

Zoe Belle Gender Collective consultation

10 PUBLISHED ARTICLES

Australian and New Zealand Mental Health Association article on the MHCC’s role and approach

Health VIC on improving accessibility for people from culturally and linguistically diverse backgrounds

Primary Health News on improving accessibility for people from culturally and linguistically diverse backgrounds

VICSERV *newparadigm*, the Australian Journal on Psychosocial Rehabilitation article on the MHCC’s work to promote equitable access and safe and inclusive services.

Appendix 02:
Operations

FINANCIAL STATEMENT FOR THE YEAR ENDED 30 JUNE 2017

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 2016–17 according to DHHS accounts is provided below.

OPERATING STATEMENT FOR THE YEAR ENDED 30 JUNE 2017

Expenses from continuing activities (includes expenses from activities carried forward from establishment)

Expenses	
Salaries and on-costs	\$2,211,951
Contractors/external services	\$549,836
Supplies and consumables	\$237,278
Total expenses	\$2,999,065

STAFFING

17.1 FTE (including fixed term positions) as at 30 June 2017, 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

In 2016–17, the MHCC made 4 FOI decisions.

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 20 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 (IBAC)
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
General enquiries: info@mhcc.vic.gov.au
www.mhcc.vic.gov.au

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