



Mental Health
Complaints
Commissioner

Annual Report Highlights 2017



About this document

This document provides highlights of the work of the Mental Health Complaints Commissioner (MHCC) for the 2016–17 financial year. Further information and detail is provided in the MHCC’s 2016–17 Annual Report (available at mhcc.vic.gov.au/resources).

Introduction

The MHCC is an independent specialist statutory body, established under the *Mental Health Act 2014 (the Act)*.

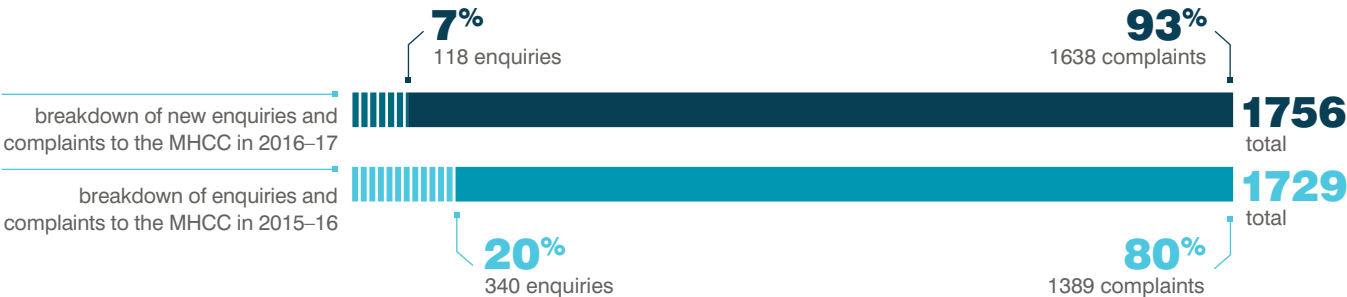
Safeguarding rights: we work to safeguard the rights of people receiving public mental health services. At the heart of our work is a focus on people’s right to receive mental health treatment in ways that support their recovery, and in accordance with the requirements and principles of the Act.

Resolving complaints: 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 work collaboratively with services to resolve complaints in ways that support people’s recovery and wellbeing.

Improving services and the mental health system as a whole: we work to ensure that the complaints people make lead to positive change and improvements in the safety and quality of mental health services for all Victorians.

Strengthening education and engagement with the sector: 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 work directly with services to support cultural change and build their capacity to provide effective responses to complaints.

Figure 1



Resolving complaints

- 1,756 new enquiries and complaints received (Figure 1)
- 281 average matters open at any one time
- 71 per cent oral complaints
- 95 per cent of complaints closed with positive outcomes through MHCC processes and/or direct resolution actions by services
- 1,341 complaints reported by public mental health services for 2016 calendar year
- 100 per cent of services provided local complaints reports.

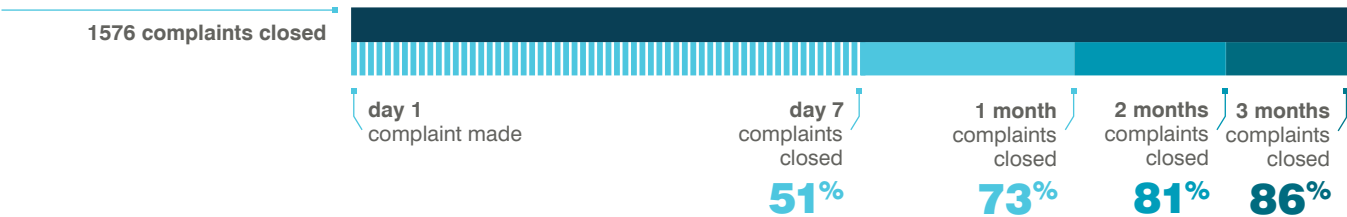
Consumers raised 1,237 (70 per cent) and family members and carers raised 416 (24 per cent) of the new enquiries and complaints made. The remaining complaints were made by advocates, legal representatives, friends and other services, or were referred from other bodies (Figure 2).

We improved our rate of early resolution and achieved positive outcomes and actions in the majority of closed complaints. 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 3).

Figure 2 how cases were raised (base: new enquiries and complaints raised with the MHCC n = 1756)



Figure 3 time taken to close complaints (base: all complaints closed by the MHCC n = 1576)



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 co-ordination 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.

Issues raised in complaints

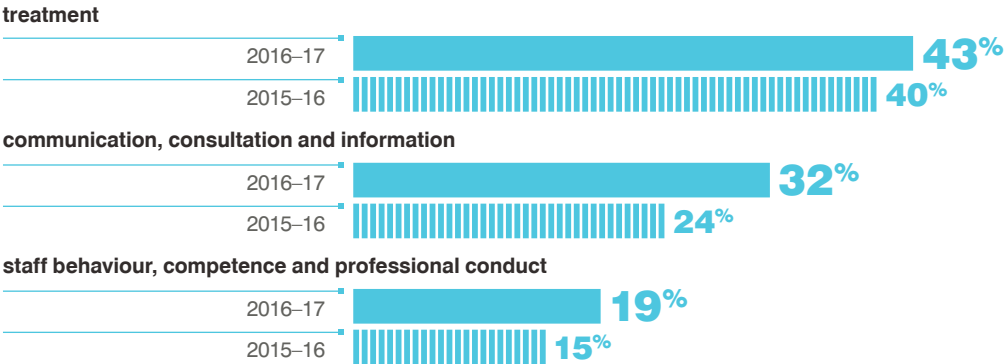
The most common issues raised in new enquiries and complaints in 2016–17 (Figure 4) were:

- treatment, 43 per cent
- communication, consultation and information, 32 per cent
- staff behaviour, competence and professional conduct, 19 per cent
- medication, 14 per cent

- access to services, 12 per cent
- discharge and transfer arrangements, 11 per cent
- environment, personal safety and management of the facility, 8 per cent.

We 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.

Figure 4
main issues raised in complaints (2016–17 against 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.

Local complaint reporting

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. In 2016–17, we introduced individual reports to mental health services to promote the use of complaints data to identify quality and safety issues and to examine the trends and differences in the data reported by services across the sector.

A total of 1,341 complaints were raised directly with mental health services during the 2016 calendar year and reported to the MHCC, compared to 1,638 complaints made directly to the MHCC between 1 January–31 December 2016 (Figure 5).

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.

We have been working with services to use the individual reports on complaints data to identify areas that may require attention and opportunities for service improvements. We also made requests to services for additional data on reported complaints where specific risk and safeguarding issues had been raised, and will continue to focus our efforts on improved reporting on complaint issues and outcomes.

Figure 5
number of complaints raised with service providers and the MHCC (1 January–31 December 2016)



We monitor and review responses to our recommendations by requesting the service or DHHS inform us of actions taken, including sending copies of any subsequent revisions to policy or procedure.

We then assess the response, and where necessary, request further information or provide advice about areas that may require further consideration.

Improving services and the mental health system as a whole

- 73 service improvements identified as outcomes of complaints
- 4 investigations conducted
- 4 formal recommendations to the Secretary of the Department of Health and Human Services (DHHS) on systemic policy and practice issues
- 34 contributions to sector consultations, projects and submissions.

Service Improvements

As a result of people making a complaint, we recorded 73 service improvements, which included a range of actions to address quality or safety issues. Last reporting period, a total of 126 service improvements were recorded, bringing the total over the past two financial years to 199 service improvement actions.

In 2016–17, service improvements recorded as outcomes of complaints included a range of actions to address quality or safety issues. Most improvements related to changes to policies and procedures (29), review of service practices (19), and training or feedback being provided to staff (17).

Policies and procedures

- 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

- 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

- 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 needs of consumers, including women in the perinatal period or people with a diagnosis of borderline personality disorder.

Other improvements

- 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 additional women-only areas.

Investigations

We 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.

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.

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.

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.

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.

Recommendations made 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.

The recommendations we made in 2016–17 related to:

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 potential risk to inpatients in acute mental health inpatient units. Accordingly, we recommended that DHHS consider setting standards and guidelines for the development of outdoor spaces in mental health acute 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, carer or family, 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 includes appropriate provisions for transitioning to the National Disability Insurance Scheme (NDIS).

Strengthening education and engagement with the sector

- 1,420 people involved in our education and engagement activities including consumers, families, carers, service staff and other stakeholders
- 85 direct education and engagement activities including presentations, training sessions and other direct engagement activities
- 97 stakeholder engagement activities

Education to services

In 2016–17, we worked 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.



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.

Engaging with consumers, families and carers

In 2016–17, we established the MHCC's Advisory Council 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.

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

- 19 education sessions reaching 848 people
- 16 targeted education and outreach activities reaching 222 people
- 50 consumer/carers engagement activities reaching 345 people
- 4 articles published in mental health journals and health publications
- 97 stakeholder engagement activities
- 3,059 social media followers.

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, through direct education and engagement activities as well as communications through our MHCC News e-bulletin, website news stories, information products and regular social media posts.

We also worked on improving our accessibility and responsiveness to priority population groups, recognising that people within these groups may experience particular barriers and challenges in raising concerns about their experience with mental health services. 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
- young and older people.



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.



Speak up. Your experience matters.



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

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